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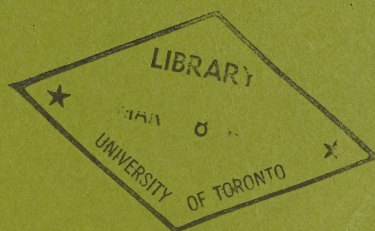
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Government
Publications

Report of the Interministry Committee on Residential Services

To the Cabinet Committee on Social Development

April, 1975



Community and Social Services

April 14, 1975

REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

PROVINCE OF ONTARIO

APRIL, 1975

Reprinted December/76

REPORT OF THE INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

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REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

SUMMARY

The task set by the Committee to meet the requirements of the Terms of Reference approved by Cabinet was divided into three Projects, affecting twenty-three of the twenty-four residential service programs identified in the Province of Ontario. Active Treatment Hospitals were excluded.

PROJECT ONE

This Project was general in nature, designed to find the means of overcoming the confusion, divergencies, and inequities, in all aspects of the twenty-three residential programs, but with more particular reference to policy and planning, cost-related classification of needs and services, utilization of resources and co-ordination at the local, regional and central levels of administration. A broad overview of the programs was completed and appropriate procedures and mechanisms for implementation were recommended in the Report.

PROJECT TWO

Project Two examined the feasibility of equalizing financial recoveries from individuals in residential care for the room and board component of the services they receive.

It was found that while the application of a universal rate would appear to have some advantages, it neither addressed itself to, nor reconciled, the underlying factors which produced the present divergent practices. It would only alleviate some of the anomalies which result from major

differences in ministerial orientation, program objectives, etc., and at the same time would create other problems.

As a flat rate charge would not appear to be desirable, it was recommended that either:

- (a) a flexible charging policy be developed as one component of a systematic review of the objectives and operations of the Provincial residential care system,
or that if (a) is not acceptable,
- (b) a rationalization of charging practices be undertaken within existing program philosophies on a target group basis.

PROJECT THREE

This was a specific Project with the purpose of developing a method of standard financial reporting that would allow for accurate comparison of per diem rates currently calculated on a different basis in almost every one of the twenty-three programs. A functional chart of accounts was prepared to serve this purpose.

Note

In the information gathering stages of this Report, concerning program procedures, statistics and costs, it was often difficult within the time available to obtain full agreement among the several Provincial personnel consulted in each of the twenty-three programs. It is therefore likely that some of the recorded detail will be disputed or variously interpreted. However, the Report is concerned much more with broad elements than precise detail and the Recommendations would not be affected by such variations. In addition there are a number of mistakes and omissions in printing which were not noted in time for correction, and no doubt, others of which we are not aware. For these we apologize, and we trust that the report will not be used as a source of precise, detailed information.

TERMS OF REFERENCE

From the August 13th, 1974 proposal by The Honourable Rene Brunelle to establish an Interministry Committee on Residential Services.

Classification of Care

1. Definition of reference points on a continuum of "care services" (i.e. from little care to extensive care).
2. Definition of reference points on a continuum of "term of care" (i.e. from short term to long term).
3. Division of responsibility to provide or finance the various types of care or services, between personal, health or welfare levels.

Target Population Groups

4. Identification or categorization of the total consumer group for long-term institutional care.
5. Delineation of the range of services to be provided to each group.

Funding and Co-ordination

6. Policy proposals relative to the ratio of private versus government operation of institutional facilities.
7. Policy proposals to determine the relative Ministry responsibility for various categories of institutional care.
8. Manner of providing financial support to the individual or institution for the levels of care required.
9. Rationalization of needs testing versus universality of care with regard to the various resident groups.

10. Identify and co-ordinate all pertinent and relative committees working in this area of care in the Ministries concerned.

I. MAJOR FINDINGS

INDIVIDUAL NEEDS, COST OF SERVICES AND LIFE STYLES

- 1.1 Residential facilities largely determine their own levels of care (ratio of staff to residents) without established classification of the needs of individual residents. One facility may treat addiction problems of youth at a staff ratio of 2 staff to 1 resident, while another uses a ratio of 1 staff to 2 residents.
- 1.2 Residential facilities largely determine their own standards of accommodation. Halfway houses for alcoholics, group homes for disturbed children, group homes for handicapped children, group homes for ex-offenders or the socially maladjusted, etc., may range in capital cost from \$6,000 per bed to \$20,000 per bed or much higher if institutions are included. These costs bear little relationship to the service needs of the individual in many cases.
- 1.3 Variations in life style including such things as food, furniture, furnishings and equipment, recreation, entertainment, spending allowances, community outings and long range trips, etc., may cost two or three times as much from one facility to another, serving the same client group.
- 1.4 High cost styles of life in residential care, some of which can only be enjoyed by the wealthy in the community, appear to

have little or no direct bearing on the service needs of the individual or the results of care. In the children's field particularly, it may be counter-productive to introduce them to a high style of life over a period of one or two years, which will be radically reduced when they return to the community.

- 1.5 Salaries of senior staff in many facilities are much higher than those of Provincial program personnel responsible for their supervision. Few effective guide lines or efforts to control such salaries exist.

CLASSIFICATION OF NEEDS AND SERVICES

(See definitions of residential facilities Appendix A)

- 1.6 The remarkable similarity of individual needs, now represented by twenty-three programs, allows them to be "broad-banded" into three main target groups: Adults, Children and Youth, and Adults in Conflict with the Law.
- 1.7 The three target groups may be used as the basis for elimination and moderation of the great divergencies in present Provincial programs through the application of guide lines.
- 1.8 The three target groups may also be used as the basis for specific classification of individual needs and corresponding services, from less intensive to more intensive, with cost levels established for each class.
- 1.9 Classification should also include non-residential alternatives for each of the three target groups: Adults, Children and Youth, and Adults in Conflict with the Law.

CO-ORDINATION AND CONTROL

- 1.10 Integrated systems of service, having the capabilities of co-ordination, admission flow and control, identification of gaps in services, advice to Government on expansion of services, advice on purchase of service, advice on phasing out antiquated and inefficient services, etc., should be created at the local and regional levels for each of the three target groups, involving the public and private sectors to a maximum degree.
- 1.11 In relation to the above, corresponding systems should be created at the Provincial level, co-ordinating the functions of the various program and financial administration centres.

FUNDING AND COST CONTROL

- 1.12 Great divergencies and inequities are noted in methods of financial recoveries from residents and parents of resident children.
- 1.13 Discretionary income and spending allowances are also inequitable and illogical, creating resentment among the users of residential services and their families.
- 1.14 Funding policies and procedures differ in almost all of the twenty-three residential programs reviewed.
- 1.15 Cost controls vary widely from minimal, to payment of a set per diem rate.
- 1.16 Comparability in stated per diem rates is almost totally lacking, indicating the need for standard financial reporting.
- 1.17 Wide variations in per diem costs for services to specific client groups cannot be justified by the measurement of results. In the circumstances, the levels of service mentioned earlier, might be used to rationalize costs.

POLICY AND PLANNING

- 1.18 Policy and planning initiatives are often presented to Cabinet and Management Board without reference to the direct effect on other programs. No consistently applied procedure for co-ordination is used.
- 1.19 Overall growth and reduction of residential services has developed without taking into account all the options across Ministry lines.
- 1.20 There is a need for interministry policy formulation related to the merits of needs testing vs. universality and consideration of the implications for Federal cost sharing.

RECOMMENDATIONS

PROJECT ONE

- I. CO-ORDINATING STRUCTURE - THAT THREE INTERMINISTRY WORK GROUPS BE ESTABLISHED, REPRESENTING THREE "BROAD-BANDED" TARGET POPULATION GROUPS ACROSS MINISTRY LINES: ADULTS, CHILDREN AND YOUTH, AND ADULTS IN CONFLICT WITH THE LAW; AND THAT THE WORK GROUPS REPORT TO CABINET THROUGH A STEERING COMMITTEE CONSISTING OF FOUR ASSISTANT DEPUTY MINISTERS RESPONSIBLE FOR RESIDENTIAL SERVICE OPERATIONS, IN THE MINISTRIES OF HEALTH, COMMUNITY AND SOCIAL SERVICES, CORRECTIONAL SERVICES AND EDUCATION, AND A PROVINCIAL CO-ORDINATOR REPORTING TO THE STEERING COMMITTEE.
- II. RESPONSIBILITIES OF WORK GROUPS - THAT THE WORK GROUPS BE INSTRUCTED TO PREPARE GUIDE LINES WITHIN SIX MONTHS, ENCOMPASSING THE FOLLOWING ITEMS, ACROSS MINISTRY LINES:
 - 2.1 LEVELS OF SERVICE - PREPARATION OF APPROPRIATE CLASSES OF NEED AND LEVELS OF SERVICE, FROM LESS INTENSIVE TO MORE INTENSIVE, TO MEET THE RANGE OF RESIDENTIAL SERVICE AND NON-RESIDENTIAL ALTERNATIVES IN EACH OF THE THREE TARGET GROUPS, ADULTS, CHILDREN AND YOUTH, AND ADULTS IN CONFLICT WITH THE LAW, WITH SUGGESTED COSTS FOR EACH LEVEL OF SERVICE.
 - 2.2 ADMISSION FLOW AND CONTROL - PREPARATION OF ALTERNATIVE METHODS OF ADMISSION FLOW AND CONTROL FOR MORE EFFECTIVE UTILIZATION OF RESOURCES, AT LOCAL, REGIONAL AND PROVINCIAL LEVELS.

- 2.3 LEGISLATION, STANDARDS AND SUPERVISION - PREPARATION OF BASIC PRINCIPLES TOWARD THE ATTAINMENT OF CO-ORDINATED LEGISLATION, STANDARDS AND SUPERVISION OF RESIDENTIAL SERVICES AND NON-RESIDENTIAL ALTERNATIVE SERVICES, FOR THE THREE TARGET GROUPS ACROSS MINISTRY LINES: ADULTS, CHILDREN AND YOUTH, AND ADULTS IN CONFLICT WITH THE LAW.
 - 2.4 ANTIQUATED FACILITIES AND INEFFICIENT SERVICES - PREPARATION OF PROPOSALS TO PHASE OUT OR REPLACE ANTIQUATED AND INEFFICIENT RESIDENTIAL SERVICES, ACROSS MINISTRY LINES, USING BOTH RESIDENTIAL AND NON-RESIDENTIAL OPTIONS.
 - 2.5 LOWER COST FACILITIES - PROPOSALS FOR THE DEVELOPMENT OF LOWER COST FACILITIES FOR CERTAIN CLASSES OF NEED NOW BEING SERVED INAPPROPRIATELY BY HIGHER COST FACILITIES.
 - 2.6 GAPS IN SERVICE - PREPARATION OF PROPOSALS CONCERNING IDENTIFIED GAPS IN SERVICE AND HOW THESE MIGHT BE FILLED, CONSIDERING THE FULL RANGE OF RESIDENTIAL AND NON-RESIDENTIAL OPTIONS, ACROSS MINISTRY LINES.
 - 2.7 PURCHASE OF SERVICE - PREPARATION OF PROPOSALS TOWARD THE ACHIEVEMENT OF BALANCE BETWEEN PROVINCIALY OPERATED, PROVINCIALY FUNDED, AND PURCHASE OF SERVICE FACILITIES AND NON-RESIDENTIAL ALTERNATIVES, ACROSS MINISTRY LINES.
 - 2.8 EQUITABLE FUNDING - PREPARATION OF PROPOSALS FOR EQUITABLE FUNDING OF FACILITIES AND SERVICES ACCORDING TO THE CLASSES OF NEED AND LEVELS OF SERVICE ESTABLISHED EARLIER. ON THIS BASIS A PARTICULAR FACILITY IN A TARGET GROUP, I.E., CHILDREN AND YOUTH, MAY SERVE VARIOUS CLASSES OF NEED AND BE RECOMPENSED AT THE VARYING RATES ASSIGNED TO EACH CLASS, ACROSS MINISTRY LINES.
 - 2.9 NEEDS TESTING AND UNIVERSALITY - PREPARATION OF PROPOSALS ADDRESSING THE COMPARATIVE MERITS OF NEEDS TESTING AND UNIVERSALITY WITH CONSIDERATION FOR FEDERAL COST SHARING.
- III. POLICY AND PLANNING - THAT FUTURE POLICY, PLANNING AND FUNDING ISSUES AND INITIATIVES BE PRESENTED JOINTLY ACROSS MINISTRY LINES TO CABINET AND MANAGEMENT BOARD, WHERE THE SERVICES CONCERNED MAY AFFECT ANY OF THE OTHER RESIDENTIAL SERVICES AND NON-RESIDENTIAL ALTERNATIVES.
- IV. MINISTRY JURISDICTION - THAT CURRENT MINISTRY JURISDICTION OF RESIDENTIAL SERVICES AND NON-RESIDENTIAL ALTERNATIVES, BE ALLOWED TO STAND UNTIL INDICATED OTHERWISE BY THE DEVELOPING IMPLEMENTATION OF THE REPORT, UNLESS REASONS FOR CHANGE HAVE ALREADY BEEN ESTABLISHED.

- V. IMPLEMENTATION OF RECOMMENDATIONS - THAT IF THE REPORT IS APPROVED, THE COMPLETED GUIDE LINES REFERRED TO IN RECOMMENDATION I, BE RETURNED TO CABINET FOR CONSIDERATION OF A FURTHER STAGE OF IMPLEMENTATION IN THE FIELD, WITH MAXIMUM INVOLVEMENT OF THE PUBLIC AND PRIVATE SERVICE DELIVERY SECTORS, AT REGIONAL AND LOCAL LEVELS. THIS IMPLEMENTATION STAGE IS PROPOSED OVER A PERIOD OF TWO YEARS.

PROJECT TWO

- VI. CHARGE FOR ROOM AND BOARD - THAT A UNIVERSAL CHARGE FOR ROOM AND BOARD NOT BE SUPERIMPOSED ON THE EXISTING RESIDENTIAL CARE STRUCTURE.
- VII. CHARGES APPLIED IN A FLEXIBLE MANNER - THAT THE PRINCIPLE OF CHARGING FOR CERTAIN ASPECTS OF RESIDENTIAL SERVICES BE ADOPTED BUT APPLIED IN A FLEXIBLE MANNER TO ACCOMMODATE DIFFERENCES IN ORIENTATION, OBJECTIVES AND CLIENT CHARACTERISTICS.
- VIII. FEDERAL COST SHARING - THAT THIS PRINCIPLE BE REFLECTED IN FORTHCOMING NEGOTIATIONS IN RESPECT TO FEDERAL COST SHARING OF INCOME MAINTENANCE AND SOCIAL SERVICES.
- IX. SYSTEMATIC REVIEW - THAT A FLEXIBLE CHARGING POLICY SHOULD BE DEVELOPED AS ONE COMPONENT OF A SYSTEMATIC REVIEW OF THE OBJECTIVES AND OPERATION OF THE PROVINCIAL RESIDENTIAL CARE SYSTEM.
- X. ALTERNATIVE TO RECOMMENDATION IX - THAT IF RECOMMENDATION NINE IS NOT ACCEPTABLE, AN INCREMENTAL RATIONALIZATION OF EXISTING CHARGING PRACTICES SHOULD BE UNDERTAKEN, PREFERABLY ON A TARGET GROUP BASIS BEGINNING WITH THE AGED.

PROJECT THREE

- XI. COST CONTROL - THAT COST CONTROL PROCEDURES BE MADE MORE UNIFORM, BEGINNING WITH STANDARD FINANCIAL REPORTING, TO ALLOW ACCURATE COMPARISON OF PER DIEM RATES AND BUDGET ITEMS.


John G. Anderson,
Chairman

INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

Mr. J. G. Anderson, Chairman	Community and Social Services
Mrs. J. Berringer	Treasury, Economics and Intergovernmental Affairs
Mr. D. Bogart	Management Board Secretariat
Dr. H. W. Henderson	Health
Mr. M. Lagace	Social Development Secretariat
Mr. A. Nuttall	Correctional Services
Mr. N. Yurchuk	Revenue
Mr. E. Magder, Co-ordinator	Community and Social Services

REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

I PROBLEM

- 1.1 The Government and the public alike are confused by the great variety of Provincial residential programs - many of them serving the same client groups - and the number of offices and Ministries involved in their administration.
- 1.2 Compounding the confusion are inconsistencies and conflicts in program philosophies, standards and supervision, eligibility and admission criteria, funding policies, cost control procedures, discretionary income and personal spending allowances, and Federal cost sharing.
- 1.3 The inconsistencies and conflicts are not only between Ministries and Policy Fields but within Ministries as well, in many cases affecting similar client groups, in other cases similar types of facilities, and frequently both.
- 1.4 Overall, in the policy making and planning processes within Government, and at the point of service delivery in the facilities, there is a basic lack of co-ordination. This often results in submissions to Cabinet and Management Board which compete with each other although they may represent the same target population group. Furthermore, there is sometimes an absence of simple communication between Ministries and programs vitally affected by unilateral initiatives.

II BACKGROUND

- 2.1 At the request of Cabinet, and acting on a proposal submitted by The Honourable Rene Brunelle, the Interministry Committee on Residential Services was established in September, 1974. Work began in mid-October,

1974, and a progress report was made to the Cabinet Committee on Social Development on January 15th, 1975, in accordance with the terms of reference contained in Mr. Brunelle's proposal. (see terms of reference, page 3) The full Report was scheduled for submission to Cabinet on April 1st, 1975.

2.2 The work of the Committee was divided into three Projects;

One - an overview of Provincial residential programs, excepting active treatment hospitals. (see summary chart, Appendix H)

Two - a feasibility study for the equalization of financial recoveries from persons in residential care.

Three - the development of a method of standard financial reporting for residential facilities.

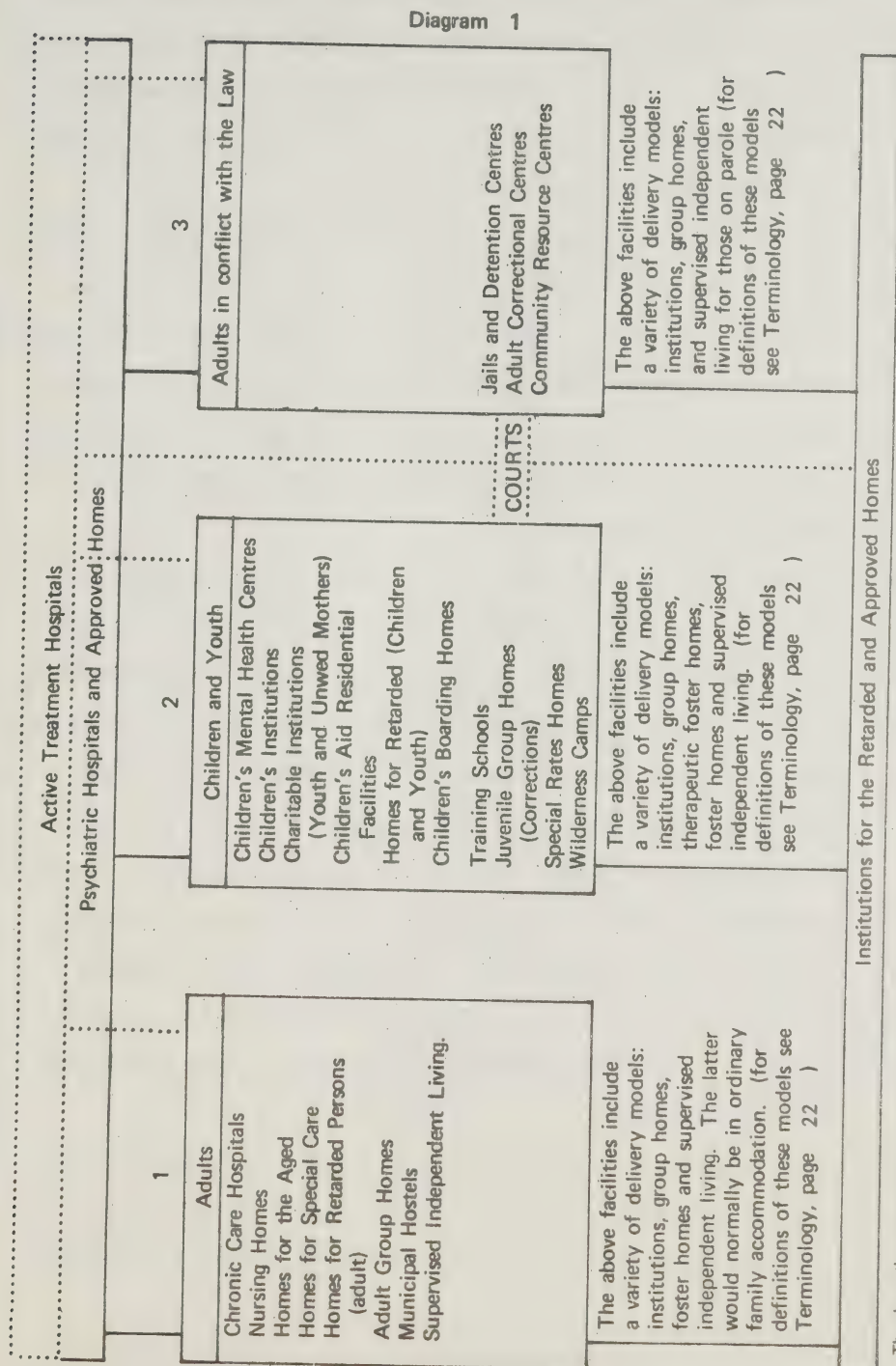
III PROJECT ONE

Purpose: to propose the means of overcoming the confusion, divergencies and inequities, found in twenty-three residential service programs in Ontario.

3.1 The overview was based on detailed descriptions and comparative analyses of twenty-three of the twenty-four residential service programs in the Ontario Government, vested in five Ministries: Health, Community and Social Services, Correctional Services, Education and the Attorney General. About fifty major centres or offices in Toronto were involved in the administration, with estimated program allocations of over \$619 million in calendar 1974. (excluding Active Treatment Hospitals)

3.2 In striking contrast to the Problem described earlier, facilities in many of the programs, and the client groups served by them, had remarkable similarities. This is diagrammed on the next page showing

INTERRELATED RESIDENTIAL SERVICES BY TARGET GROUPS (1, 2 AND 3)
"BROAD BANDED"

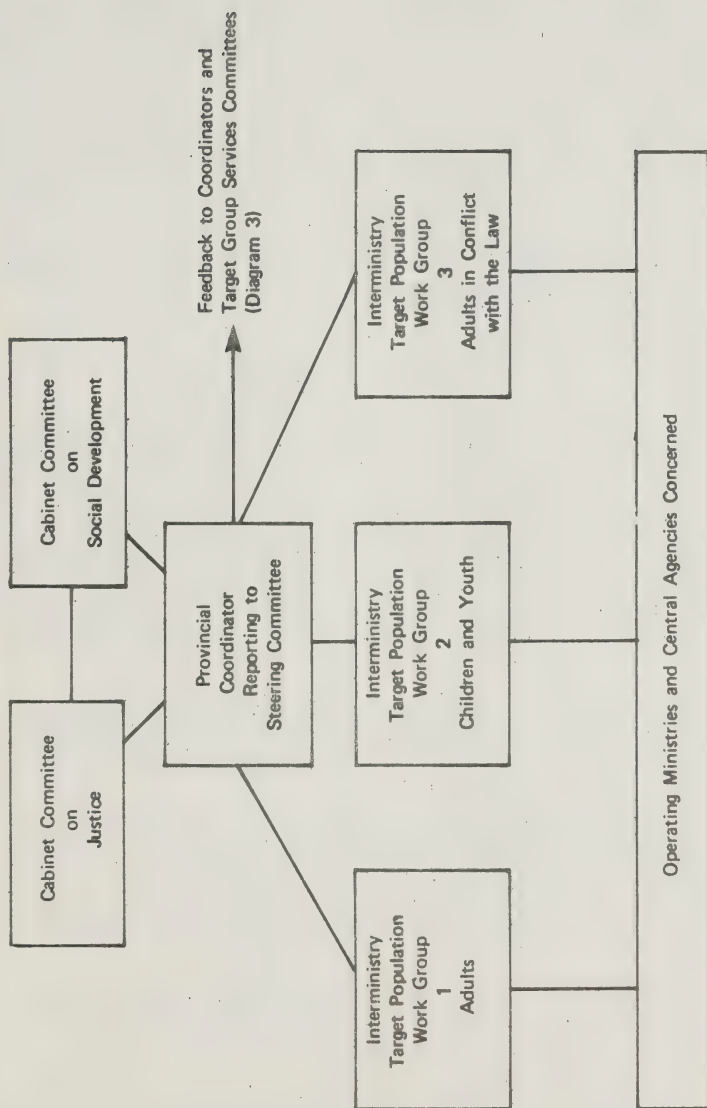


twenty-one of the programs, serving three "broad-banded" target population groups. The remaining two programs serve the population as a whole, and act as "back-up" facilities for the other programs. Active Treatment Hospitals also serve this broad spectrum of the population and provide a back-up function.

- 3.3 The similarities of the facilities, and the client groups served, made it possible to "broad-band" them, and led directly to the proposed resolution of the Problem. It appeared logical to conceive a structure based on these similarities, and use it to eliminate or moderate the inconsistencies and conflicts, and, at the same time, provide for the co-ordinated action of the Ministries and Central Agencies concerned.
- 3.4 The structure was designed in two separate stages as shown in the models on pages 15 & 16. The model on page 15 was designed mainly for the preparation of guide lines, for proposed completion in six months. It is suggested that the guide lines would then be brought back to Cabinet with a further plan for implementation in the field over a period of two years. The suggested model for this second stage is shown on page 16, but by that time the experience gained in preparation of the guide lines should make it possible to produce several alternative proposals. In any event, the preparatory interministry discussions would have considerable value in themselves. This has, to a degree, already been indicated by the work of the present Committee.
- 3.5 It is proposed that the first stage, preparation of guide lines, be staffed by program managers or senior Provincial program personnel from the twenty-three residential programs. It may also be useful

Diagram 2

MODEL FOR THE DEVELOPMENT OF INTERMINISTRY PROGRAM GUIDE LINES
(time limited structure)

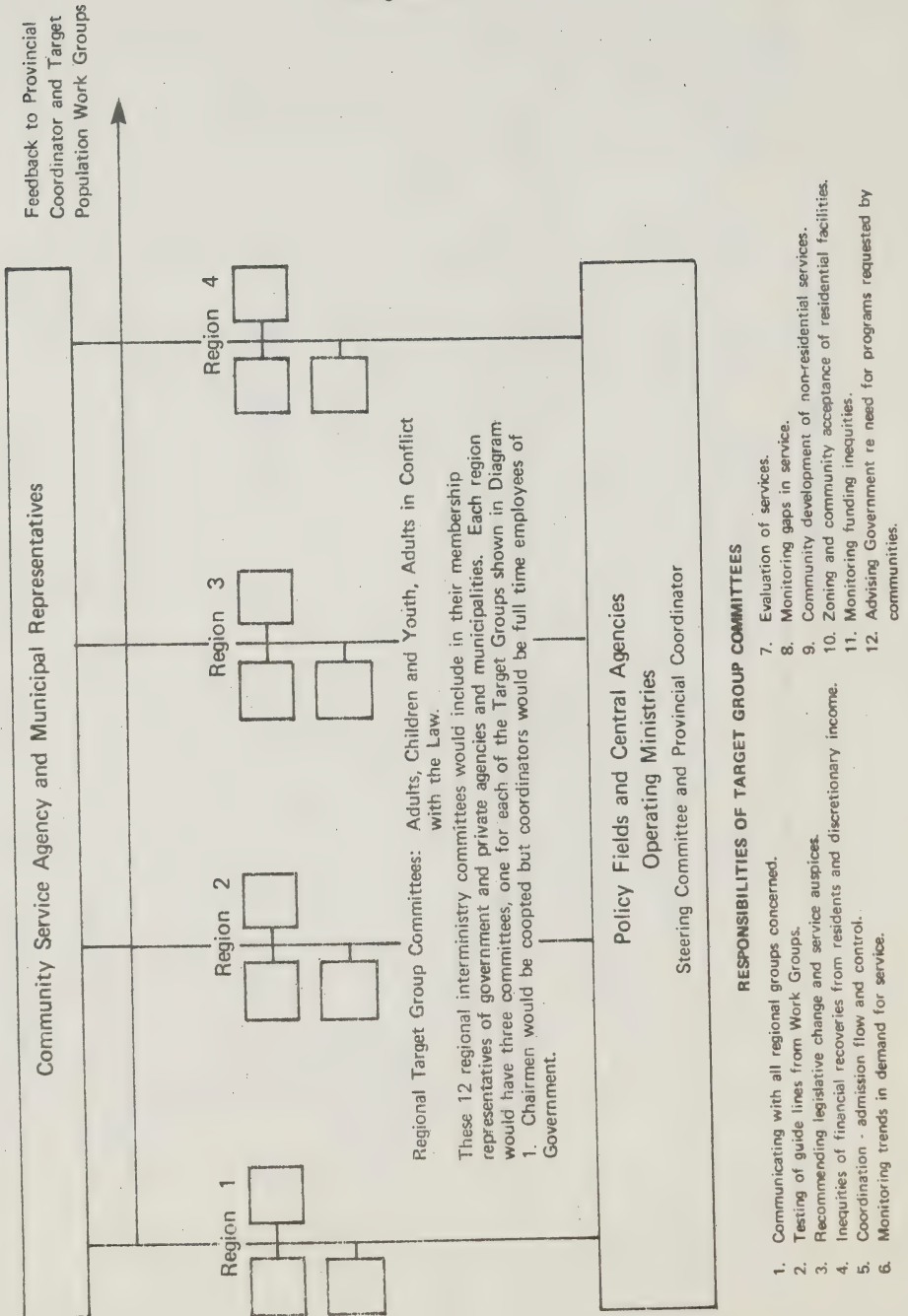


RESPONSIBILITIES OF INTERMINISTRY TARGET POPULATION WORK GROUPS:

1. Specification of target group.
2. Classification of persons in need of service.
3. Identification of services required and gaps (private and public agencies).
4. Policy concerning purchase of service.
5. Identifying antiquated facilities and service duplication.
6. Evaluation of services (cost/benefit).
7. Design of admissions and flow control system.
8. Non-residential alternatives.
9. Communications patterns.
10. Consideration of federal cost sharing.
11. Revision of guide lines on feedback from Target Group Services Committees.
12. Comment on interministry issues and problems.

Diagram 3

OPTIONAL MODEL FOR EVALUATION AND IMPLEMENTATION OF PROGRAM GUIDELINES (time limited structure)



to add representation from the Active Treatment Hospital program because of its far reaching relationships throughout the health, social service and corrections networks. Since the guide lines would become the basic documents of the ensuing process, it is suggested that the personnel be allowed sufficient freedom of their regular program duties to do the job adequately. The nature of the task is such that personnel with a substantial depth of experience at a senior level within the programs themselves are required, and others, however able, would be unsuitable.

RECOMMENDATIONS

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IV PROJECT TWO

Purpose: to examine the feasibility of equalizing financial recoveries from individuals in residential care.

- 4.1 Introduction of the GAINS (AGED) program had implications for many residential care clients. GAINS payments were intended to assist low income aged persons in the community to meet high living costs. If GAINS benefits had been passed on to persons whose needs were already being met through residential care programs at little or, in some cases, no charge, multiple subsidization would have occurred.

This problem was resolved in part by the introduction of increases in the Extended Care co-insurance rate. However, some multiple subsidization continued as GAINS benefits were paid to clients of other residential facilities.

This situation, in turn, raised questions concerning the possibility of introducing a universal recovery charge to all residential care clients. That is, a flat rate charge to cover the costs of "room and board" in these facilities.

4.2 CONCLUSION

1. A universal residential charge will not reconcile fundamental differences in orientation, objectives, etc. It will only alleviate some of the anomalies which result from these differences, and create many other problems.
2. However, the development of a broad "charging policy" which is sufficiently flexible to accommodate differences in orientation, program objectives and client characteristics, appears to have considerable merit.

3. If such a policy were adopted, two alternative approaches appear to be possible:

(a) development of a "charging policy" as one component of a wider, overall re-assessment of residential care policies and practices; i.e., the "charging policy" must reflect the fundamental orientation and goals of residential care programs.

(b) acceptance of an incremental approach; i.e., a step by step rationalization of charging on a target group basis within existing constraints.

(see Appendix B for the full summary of Project Two)

RECOMMENDATIONS

- VI. CHARGE FOR ROOM AND BOARD - THAT A UNIVERSAL CHARGE FOR ROOM AND BOARD NOT BE SUPERIMPOSED ON THE EXISTING RESIDENTIAL CARE STRUCTURE.
- VII. CHARGES APPLIED IN A FLEXIBLE MANNER - THAT THE PRINCIPLE OF CHARGING FOR CERTAIN ASPECTS OF RESIDENTIAL SERVICES BE ADOPTED BUT APPLIED IN A FLEXIBLE MANNER TO ACCOMMODATE DIFFERENCES IN ORIENTATION, OBJECTIVES AND CLIENT CHARACTERISTICS.
- VIII. FEDERAL COST SHARING - THAT THIS PRINCIPLE BE REFLECTED IN FORTHCOMING NEGOTIATIONS IN RESPECT TO FEDERAL COST SHARING OF INCOME MAINTENANCE AND SOCIAL SERVICES.
- IX. SYSTEMATIC REVIEW - THAT A FLEXIBLE CHARGING POLICY SHOULD BE DEVELOPED AS ONE COMPONENT OF A SYSTEMATIC REVIEW OF THE OBJECTIVES AND OPERATION OF THE PROVINCIAL RESIDENTIAL CARE SYSTEM.
- X. ALTERNATIVE TO RECOMMENDATION IX - THAT IF RECOMMENDATION NINE IS NOT ACCEPTABLE, AN INCREMENTAL RATIONALIZATION OF EXISTING CHARGING PRACTICES SHOULD BE UNDERTAKEN, PREFERABLY ON A TARGET GROUP BASIS BEGINNING WITH THE AGED.

V PROJECT THREE

Purpose: to establish the basis for more uniform and effective cost control through accurate comparison of per diem rates and budget items.

- 5.1 A sub-committee of senior financial analysts from the operating Ministries was established to consider the question of standard financial reporting by residential facilities. As in the findings of Projects One and Two, this sub-committee found great divergency in the existing methods of recording and reporting financial information. Stated per diem rates of facilities from program to program and even within the same program were therefore not comparable.
- 5.2 The sub-committee agreed that the appropriate instrument was an accounting system based on functions, and accordingly, produced a prototype chart of accounts. They were confident that this system could be applied to all residential facilities, providing for accurate comparison of per diem rates and specific cost units, i.e., administration, accommodation, food services, nursing services, medical services, psychological services, etc.

There was, however, insufficient time to refine and validate the system in the field, with particular reference to some of the more problematic variations. A period of three months would be required to complete this process.

(for complete report of Project Three and chart of accounts see Appendix C)

RECOMMENDATION

- XI. COST CONTROL - THAT COST CONTROL PROCEDURES BE MADE MORE UNIFORM, BEGINNING WITH STANDARD FINANCIAL REPORTING, TO ALLOW ACCURATE COMPARISON OF PER DIEM RATES AND BUDGET ITEMS.

APPENDIX A

TERMINOLOGY

In the establishment of any co-ordinated system of services terminology is vital to the distinction between one part of the system and another and to an understanding of how the parts fit together. It is hoped that the task of classification of needs and services proposed in this Report will include the development of a widely accepted terminology.

The following terms are offered as a first attempt to define the various methods of delivering residential services.

Residential Facilities

A generic term referring to facilities generally intended to provide twenty-four hour accommodation, food services, care or treatment over a wide time span from a single day to many years, for persons who may have one or any number of health, mental, emotional, social, family, anti-social, educational, financial or location problems, which prevent them from living in their own homes. Frequently residential facilities include a follow-up element to assist persons leaving the residence to become re-established in the community. They may also include day care and a number of other services for those persons who are able to continue living in their own homes with outside support.

Institutions

Residential facilities at the larger end of the scale, generally from 25 to 500 or more resident beds with specialized staff and centralized food, housekeeping, maintenance and administrative services. These are found across the whole spectrum of service

for persons with mental, emotional or physical disabilities, or special education and training needs, or the need for simple domiciliary care, or those in conflict with the law. Examples: Psychiatric Hospitals, Homes for the Aged, Nursing Homes, some Homes for Special Care, Jails and Correctional Centres.

Group Homes

Residential facilities at the smaller end of the scale, generally with 4 to 12 resident beds. These facilities are based on the surrogate family pattern with the emphasis on developing attitudes and skills toward responsible and independent living in the community. Examples: Children's Mental Health Centres, Children's Institutions, Children's Aid Group Homes, Correctional Group Homes, some Homes for Retarded Persons, Community Resource Centres.

Hostels

Residential facilities on either the institutional or group home models providing short-term service of several days to several weeks, and less typically up to a few months. These facilities are for persons who need primarily temporary food, lodging and other personal amenities, and are without sufficient funds to purchase them independently. Some counselling may also be given. Examples: Municipal Hostels, Travellers Hostels, Youth Hostels, Short-Term Care and Referral Centres.

Domiciliary Residences

Residential facilities on the institutional, group home or foster home models providing care generally from 6 months to 5 years or more. Persons served may have mental, emotional, social or physical disabilities not serious enough for specialized care or treatment

but who are unable to care for themselves without some assistance. Examples: Homes for Special Care, Approved Homes, some Homes for Retarded Persons, Satellite Homes for the Aged.

Therapeutic Foster Homes

Residential facilities for 1 or 2 persons who require intensive care or treatment and are able to live with a foster family established in the community. Emphasis is on the benefit to be derived from family and community experience. Services would include specialized outside staff support. Examples: some Children's Mental Health Centres, some Children's Boarding Homes, some Children's Aid Homes.

Foster Homes

Residential facilities for 1 or 2 persons who require minimal care or supervision and are able to live with a foster family established in the community with a minimum of outside staff support. Examples: Children's Aid Foster Homes, Homes for the Aged Foster Homes, some Homes for Special Care, some Approved Homes.

Supervised Independent Living

Residential facilities in normal family dwellings, housing generally 1 to 6 persons able to live independently in the community with part-time assistance, supervision or counselling. Examples: senior citizens, mildly retarded persons, physically handicapped, parolees and ex-offenders.

Atypical Facilities and Projects

The Facilities may be similar to any of the above but because of size, program or class of persons served do not fall clearly within

the terms described; also special projects with a live-in element. Examples: Facilities that are a combination of several of the facilities described previously, wilderness and other camps, "outward-bound" projects, travel projects, oversize Group Homes, some Municipal Hostels, Institutions using the cottage or unit mode.

APPENDIX B

PROJECT TWO - COMPLETE SUMMARY

INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

IV PROJECT TWO

4.1 INTRODUCTION

Introduction of the GAINS (AGED) program had implications for many residential care clients. GAINS payments were intended to assist low income aged persons in the community to meet high living costs. If GAINS benefits had been passed on to persons whose needs were already being met through residential care programs at little or, in some cases, no charge, multiple subsidization would have occurred.

This problem was resolved in part by the introduction of increases in the Extended Care co-insurance rate. However, some multiple subsidization continued as GAINS benefits were paid to clients of other residential facilities.

This situation, in turn, raised questions concerning the possibility of introducing a universal recovery charge to all residential care clients. That is, a flat rate charge to cover the costs of "room and board" in these facilities.

4.2 OBJECTIVE

To examine the feasibility of equalizing financial recoveries from individuals in residential care.

4.3 CURRENT SITUATION

At present, there is no overall policy regarding charges to individuals in residential care facilities. A broad range of practices exist - from

situations in which no direct charge is made against the client as all services are covered by health insurance, to situations in which facilities attempt to recover all of the costs from the client, or his family. For example, practices vary:

- by client groups (e.g., mentally retarded are treated differently than the aged);
- within client groups (e.g., the aged in a Home for the Aged are treated differently than those in a Home for Special Care);
- within the same facility (e.g., residential care clients in Homes for the Aged are treated differently than extended care clients in the same home);
- by different facilities which provide essentially the same level of care (e.g., supervised board and lodging for aged persons are provided by both Homes for Special Care - Residential Homes and Licenced Approved Homes under Psychiatric Hospitals - but the charges are different);
- without relationship to the degree of service provided by the facility (e.g., a chronic care hospital resident receiving a minimum of 76 hours of nursing care per month on average pays nothing for room, board or health care, while a residential care client in a Home for the Aged is billed an average \$360 per month);
- without relationship to ability to pay (e.g., a wealthy resident on extended care in a Home for the Aged pays about one half of the average amount billed a person in residential care in the same Home for the Aged);
- in relation to the source of income (e.g., Adult Group Homes for the Physically Disabled have based their charge on the level of

income provided by the GAINS (DISABLED) program.)

- according to Provincial legislative requirements (e.g., facilities under the Charitable Institutions Act must meet 20% of their operating costs with non-government funds and have to adjust their resident charges accordingly);
- according to Federal legislative requirements (Canada Assistance Plan (e.g., in M.R. Schedule I facilities, residents are billed \$30 per day, in order to obtain cost sharing in those facilities);
- with the objectives of the program (e.g., M.R. community residences do not charge a resident all his GAINS (DISABLED) income so that the resident can learn how to use funds wisely;
- against the objectives of the program (e.g., the assets of M.R. Schedule I clients are assessed at the rate of \$30 per day to facilitate cost sharing which taxes the resources of an individual which he may require to be self-sufficient on his return to the community).

These variations appear to result in situations which are not only in conflict but are also inexplicable to the general public.

For example, comparisons can be made between situations in which:

- the charges for government services decrease as the amount of service increases;
- the "poorest" clients may appear to pay the highest charges.

4.4 CONSTRAINTS

It was considered that the introduction of a uniform room and board charge for all residential facilities might have a number of advantages. For example:

- reinforcement of individual responsibility;
- increased equity;
- simplified administration;
- greater consistency and ease of public understanding.

However, the introduction of a universal room and board rate does not either address itself to, or reconcile the underlying factors which have produced the existing situation.

Variations in charging practices appear to be caused by three major factors.

1. Ministerial Orientation - Residential care is provided primarily by the Ministries of Health and Community and Social Services.

The Ministries differ markedly in respect to:

- (a) Policy Orientation - Health services are based on a universal service concept using a social insurance mechanism. In contrast, MCSS programs are based on a more selective service concept with an orientation toward a "welfare or needs tested" approach.
- (b) Cost Sharing Provisions - Reflects the policy orientation of the respective ministries. That is, the "needs oriented" Canada Assistance Act versus the Hospital Insurance and Diagnostic Services Agreement and Medical Care Agreement.

2. Individual Program Objectives

3. Clients' Income Source and Ability to Pay

The introduction of a universal room and board charge across all residential care programs assumes that these fundamental differences in Ministerial orientation, program objective and clients' ability to pay are either:

1. sufficiently compatible to accept this adjustment, or
2. can be readily adjusted to facilitate the introduction of a universal charge for room and board without adverse implications.

Neither condition appears to exist at present.

Differences in orientation are profound; e.g.

- the introduction of a charge for room and board in certain health facilities would be more compatible with the MCSS approach, but would infer a fundamental policy change in respect to benefits provided through health insurance.
- Similarly, application of the extended care rate in M.R. facilities might jeopardize their cost sharing under CAP.

It would also appear to be inappropriate to introduce a universal charge when major changes in both income maintenance and cost sharing of social services may occur during the next two years.

4.5 CONCLUSION

1. A universal residential charge will not reconcile fundamental differences in orientation, objectives, etc. It will only alleviate some of the anomalies which result from these differences, and create many other problems.
2. However, the development of a broad "charging policy" which is sufficiently flexible to accommodate differences in orientation, program objectives and client characteristics, appears to have considerable merit.

3. If such a policy were adopted, two alternative approaches appear to be possible:
- (a) development of a "charging policy" as one component of a wider, overall re-assessment of residential care policies and practices; i.e., the "charging policy" must reflect the fundamental orientation and goals of residential care programs.
 - (b) acceptance of an incremental approach; i.e., a step by step rationalization of charging on a target group basis within existing constraints.

(see Appendix B for the full summary of Project Two, page 26)

RECOMMENDATIONS

- VI. CHARGE FOR ROOM AND BOARD - THAT A UNIVERSAL CHARGE FOR ROOM AND BOARD NOT BE SUPERIMPOSED ON THE EXISTING RESIDENTIAL CARE STRUCTURE.
- VII. CHARGES APPLIED IN A FLEXIBLE MANNER - THAT THE PRINCIPLE OF CHARGING FOR CERTAIN ASPECTS OF RESIDENTIAL SERVICES BE ADOPTED BUT APPLIED IN A FLEXIBLE MANNER TO ACCOMMODATE DIFFERENCES IN ORIENTATION, OBJECTIVES AND CLIENT CHARACTERISTICS.
- VIII. FEDERAL COST SHARING - THAT THIS PRINCIPLE BE REFLECTED IN FORTHCOMING NEGOTIATIONS IN RESPECT TO FEDERAL COST SHARING OF INCOME MAINTENANCE AND SOCIAL SERVICES.
- IX. SYSTEMATIC REVIEW - THAT A FLEXIBLE CHARGING POLICY SHOULD BE DEVELOPED AS ONE COMPONENT OF A SYSTEMATIC REVIEW OF THE OBJECTIVES AND OPERATION OF THE PROVINCIAL RESIDENTIAL CARE SYSTEM.
- X. ALTERNATIVE TO RECOMMENDATION IX - THAT IF RECOMMENDATION NINE IS NOT ACCEPTABLE, AN INCREMENTAL RATIONALIZATION OF EXISTING CHARGING PRACTICES SHOULD BE UNDERTAKEN, PREFERABLY ON A TARGET GROUP BASIS BEGINNING WITH THE AGED.

APPENDIX C

REPORT OF THE

INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

PROJECT THREE

An interministry sub-committee of senior financial consultants representing the Ministries of Health, Community and Social Services, Correctional Services and Education reviewed the accounting systems of the various types of residential facilities. The general program and financial information already collected for Project One indicated great divergency in the existing methods of recording and reporting financial information and this fact was again confirmed by the sub-committee. Only very few of the systems provided for recording on a functional basis and there was no standardization even among those.

The sub-committee agreed that an accounting system reporting costs on a functional basis was the appropriate system. (see proposed chart of accounts at the end of this Appendix) This system should facilitate the provision of accurate, comprehensive information making possible comparisons of standard selected costs of facilities within a designated Target Group and also across Target Groups if desired. The new system would not, of course, be more likely to guarantee the accuracy of individual items any more than other systems, but over a period of use and comparison, cost items should gradually be refined to close tolerances.

The sub-committee further agreed that all residential facilities had similar "basic functions", i.e., building and property, food,

administration, etc. These functions were numbered 1 to 6 on the chart of accounts. Each facility also had a program or services to meet the objectives for which it was established and these were represented by cost units in function 7 on the chart.

Although the basic functions (1-6) would be much more readily comparable than service or program units, it should be possible through experience over time to arrive at comparable unit formulations for both basic and program or service functions (7). Such variations as the employment of a physician or a psychiatrist in one facility, and purchase of service in another, could be gradually absorbed into, and tolerated by the system.

If there were a requirement for a facility to break out its costs by service or program divisions, the functional accounts might be used in the same way for each division by allocation of its functional costs. In this way divisional costing within a facility would be consistent with the overall functional cost system of the whole facility.

The sub-committee believed that the functional accounting system, in addition to providing standard unit cost information, might also contribute to better cost analysis and administration within the facilities. For example, they might make a better informed choice between contracted and internally provided food services, particularly if the experience of other similar facilities were available to them. But in the final analysis such improvements always depend upon the motivation and competence of the administrator. This is of particular

interest when comparing profit-oriented and non-profit facilities when looking at the advantages and disadvantages of these options. Most of the hospitals funded by the Ministry of Health, and the Homes for the Aged funded by Community and Social Services, were provided with unit costs of their various operations in a readily comparable form.

It was noted that a number of categories of residential facilities provide non-residential services, i.e., counselling, after-care, consultation with schools and other agencies, etc. The functions for non-resident services have not been included in the chart of accounts but it should be possible to develop similar functional costs for such services without great difficulty.

The comprehensive and detailed accounting and reporting structures outlined in this report are only suitable for residential facilities with appropriate administrative resources. The benefits of maintaining such a detailed system in the small facilities would not justify the cost. However, the small facilities could continue their current accounting practices and use a summarized version of the functional system to report costs quarterly or half-yearly. The sub-committee agreed that the functional report could be adapted for this purpose without difficulty, but it would perhaps be necessary to offer the administrators more assistance through Provincial financial consulting services.

In further developing the functional reporting system, previous studies should be taken into account such as the joint Health/Community and Social Services Task Force, to provide an inventory of basic information

on institutional care. (submitted November 14th, 1973)

Because residential facilities do not now record costs on a standard functional basis, it has not been possible to fully test this system in all the operating Ministries. However, a similar functional system is being operated successfully in at least one category of residential facilities and the Committee is confident that it will work in the other categories. The first steps taken to establish the functional system throughout the residential facilities considered in this report will not be easy, but its eventual success should provide many benefits in the long term.

The above proposal is an integral part of the Committee report and recommendations. It should, however, be possible to implement the application of the functional chart of accounts independently since the benefits would be valid whether or not the main proposals of the full report are accepted.

The Committee suggests that implementation of the functional chart of accounts should not necessarily require changes in existing accounting practice in the Ministries. We believe that in most cases it merely represents an additional reporting capability that will be of particular use to Cabinet and Management Board.

Residential Facilities - Functional Accounting

	Applicable in Ministry			
	Attorney General	Community and Social Services	Correctional Services	Education
Health				
1. Building and Property - Operation and Maintenance				
Salaries - Supervisory (First Line)				
- other				
Employee benefits				
Purchased services				
Heating				
Other utilities - gas, electricity, etc.				
Garbage collection				
Taxes				
Insurance - plant, boiler, equipment				
Long term debt servicing (if allowed)				
Rent				
Buildings and grounds - repairs and maintenance				
- replacements				
- depreciation (if allowed)				
Equipment - operation and maintenance				
- replacements				
- depreciation (if allowed)				
Other				

Applicable in Ministry				
Attorney General	Community and Social Services	Correctional Services	Education	Health

2. Housekeeping Services

Salaries - supervisory (first line)

- Other

Employee benefits

Purchased services

Miscellaneous supplies

Equipment - operation and maintenance

- replacements

- depreciation (if allowed)

Other

3. Laundry and Linen Services

Salaries - supervisory (first line)

- other

Employee benefits

Purchased services

Replacements - bedding, linen

- uniforms

- other

Miscellaneous supplies

Equipment - operation and maintenance

Applicable in Ministry			
Attorney General	Community and Social Services	Correctional Services	Health

Equipment - replacements
- depreciation (if allowed)

Other

4. Food Services

Salaries - supervisory (first line)

- other

Employee benefits

Purchased services

Raw food

Replacements - dishes, cutlery, etc.

Miscellaneous supplies

Equipment - operation and maintenance

- replacement

- depreciation (if allowed)

Other

Applicable in Ministry				
Attorney General	Community and Social Services	Correctional Services	Education	Health

5. Clothing and Personal Needs

Clothing - purchases

- cleaning

Personal allowances

Funeral and burial

Other

6. Administration

Salaries - Chief Executive Officer

- other full time

- other part time

- temporary

Employee benefits

Purchased services (specify, e.g. bookkeeping and accounting services)

Advertising and public relations

Audit

Insurance - P.L./P.D., etc.

Legal

Office supplies, postage, printing and stationery

Applicable in Ministry

Attorney General	Community and Social Services	Correctional Services	Education	Health

Telephone

Bank charges

Bank interest (if allowed)

Staff travelling and convention (non-program related)

Training courses (non-program related)

Vehicle operation

Equipment - operation and maintenance

- replacements

- depreciation (if allowed)

Other

Applicable in Ministry

Attorney General	Community and Social Services	Correctional Services	Education	Health

7. Program Activities

Salaries Health Services

medical doctors

Psychiatrists

Nursing services

Dentists

Laboratory services

Other

Counselling Services

Social workers

Adjuvants

Child care workers

Chaplains

Psychotherapists

Other

Psychological Services

Psychologists

Psychometrists

Other

Applicable in Ministry				
Attorney General	Community and Social Services	Correctional Services	Education	Health

Education and Training

Teachers

Vocational and academic - residents

- staff

Industrial and work projects

Speech therapists

Physiotherapists

Occupational therapists

Speech therapists

Other

Correctional

Correctional and custodial officers

Recreation

Recreation and sport

Hobbies and crafts

Other

Specify

Employee benefits

Physicians fees

Applicable in Ministry				
Attorney General	Community and Social Services	Correctional Services	Education	Health

Purchased services (specify)
 Transportation and convention (program related)
 Training courses (program related)
 Equipment and supplies
Supplies
 Drugs and pharmaceuticals
 Medical/nursing
 Teaching
 Recreation/sport/hobby/craft
 Other
Equipment
 Repairs and maintenance
 Replacement
 Depreciation (if allowed)

APPENDIX D
REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

ANALYSIS OF TWENTY-THREE PROGRAM REPORTS
ON RESIDENTIAL SERVICES IN THE PROVINCE OF ONTARIO

SUMMARY

This comparative analysis and commentary shows opportunities that exist to use the natural growth and development of residential services in three Target Groups, Adults, Children and Youth and Adults in Conflict with the Law, as a basis for the development of rational systems of service according to the mechanisms described in Project One.

The information in this analysis is abstracted from the detailed reports on each of the twenty-three residential programs. The detailed reports are included in the Supplementary Appendices, Appendix N^o

There is also a charted summary of all the information collected on the programs shown in Appendix H of this Report.

ANALYSIS OF PROGRAM REPORTS ON TWENTY-THREE
RESIDENTIAL PROGRAMS IN THE PROVINCE OF ONTARIO

The following analysis is organized according to the three Target Groups, Adults, Children and Youth and Adults in Conflict with the Law. Psychiatric Hospitals and Mental Retardation Facilities I and II are not included since they serve the whole range of ages and needs. They will be discussed separately at the end.

For a more detailed description of the individual programs see Appendix N in the Supplementary Appendices.

TARGET GROUP 1 - ADULTS

	<u>Beds</u>	<u>Facilities</u>	<u>Budget 74/75 \$ Millions</u>	<u>Utilization</u>
Chronic & Private Chronic Care Hospitals	3,650	31	85.5	94%
Nursing Homes	25,000	413	118.3	98%
Homes for the Aged	26,300	176	67.4	90%
Homes for Special Care, Residential	1,941	272	6.1	95%
Homes for Retarded Persons (adult)	457	22	2.0	95%
Adult Group Homes	510	24	1.7	85%
Municipal Hostels (served 94,000 welfare recipients in 1974)	?	?	1.8	?
Totals	<u>57,858</u>	<u>938</u>	<u>282.8</u>	<u>---</u>

TARGET GROUP 1 - ADULTS

Provincial Legislation - Specific

Chronic & Private Chronic Care Hospitals	Public Hospitals Act, Private Hospitals Act, Health Disciplines Act.
Nursing Homes	Nursing Homes Act, Public Health Act, Health Insurance Act.
Homes for the Aged	Homes for the Aged and Rest Homes Act, Charitable Institutions Act, Elderly Persons Centres Act, Health Insurance Act.
Homes for Special Care Residential	Homes for Special Care Act.
Homes for Retarded Persons (adult)	Homes for Retarded Persons Act, Developmental Services Act, 1974.
Adult Group Homes	Charitable Institutions Act.
Municipal Hostels	General Welfare Assistance Act.

General

Health Insurance Act, Family Benefits Act, General Welfare
Assistance Act. GAINS, individual Ministry Acts.

TARGET GROUP 1 - ADULTS

	<u>Provincial Centres of Administration</u>	<u>Ministry</u>
Chronic & Private Chronic Care Hospitals	Institutional Operations Branch	
	Medical and Nursing Branch	
	Financial Controls Branch	
	Regional Co-ordinators	<u>HEALTH</u>
Nursing Homes	Inspection Branch	
	Medical and Nursing Branch	
	Allied Health Disciplines Branch	
	Financial Controls Branch	
	Regional Co-ordinators	<u>HEALTH</u>
Homes for the Aged	Senior Citizens Bureau	
	Capital Services Branch	
	District Directors	
	Regional Executive Directors	<u>COMSOC</u>
Homes for Special Care Residential	Psychiatric Hospitals Branch	
	Inspection Branch	<u>HEALTH</u>
Homes for Retarded Persons (adult)	Children's Services Bureau	
	Capital Services Branch	
	Mental Retardation Community Service Development Branch	
	District Directors	
	Regional Executive Directors	<u>COMSOC</u>

	<u>Provincial Centres of Administration</u>	<u>Ministry</u>
Adult Group Homes	Rehabilitation Bureau	
	Capital Services Branch	
	District Directors	
	Regional Executive Directors	<u>COMSOC</u>
Municipal Hostels	Municipal Welfare Consulting Unit	
	District Directors	
	Regional Executive Directors	<u>COMSOC</u>

Provincial Benefits Branch and GAINS Program
provide income maintenance to all of the
above programs.

COMSOC

Comment: This broad spread of administrative structures appears very
inconsistent with the unified nature of the group and the
similarity of the services.

ANALYSIS OF TARGET GROUP 1 - ADULTS

Most of this group of more than 55,000 persons are aged and ill. They represent a highly unified aggregate of needs and are served by very similar facilities.

Based on these facts it should be possible to develop a clear continuum of care with defined levels of service, each level being accorded a specific cost. This would eliminate the artificial distinctions implied in the arbitrary labels, Nursing Home, Home for the Aged, Chronic Care, etc. It should also be possible to control admission and flow to make the most of the beds available in contrast with the wasteful competition that now exists. Accusations and counter accusations are made between the facilities as they jockey for the best "mix" of clients. Since each facility determines its own admission policy and decides when to release a client, institutional gamemanship detracts from service effectiveness. This effect is heightened when the competition is between profit oriented facilities and charitable and community facilities.

Funding is another focus of competition with each group and sometimes each facility bargaining separately.

Wide varieties of legislation, standards, methods of supervision and inspection, funding and cost control spawn numerous offices and centres of authority in Government. Target Group 1 - highly unified in needs and service modes - is represented by more than twenty-four centres of authority in two Ministries, each Ministry having a basically different service philosophy.

Standards, supervision, and funding follow the same highly varied pattern, confusing both to program personnel and public alike. Perhaps the most serious matter is the lack of non-residential alternatives. Despite the established trend away from institutional care, Ontario gives its seniors a strong financial incentive to go inside, especially those on Extended Care. Firstly they are able to live in a style they would be unable to pay for in the community out of OAS-GIS, GAINS, Family Benefits and pensions. Secondly, many of them can save money while in residence. In Toronto alone funds held in trust for residents of homes for the aged in Extended Care, saved out of comfort allowances alone, are estimated to be growing at over \$1 million per year. On the death of the resident, funds pass to the estate of the deceased. In the meantime the aged person in the community can barely make ends meet and has extremely little in the way of service to help him stay there.

The irony is that very few people go into institutions without a great deal of reluctance.

For a more detailed description of the programs see Appendix N in the Supplementary Appendices.

TARGET GROUP 2 - CHILDREN AND YOUTH

	<u>Beds</u>	<u>Facilities</u>	<u>Budget 74/75 \$ Millions</u>	<u>Utilization</u>
Children's Mental Health Centres	920	26	15.8	unknown
Children's Institutions	1,056	38	4.0	80%
Charitable Institutions Youth and Unwed Mothers	406	20	.9	72%
Children's Aid Societies Residential Facilities	1,550	235	8.4	75%
Homes for Retarded Persons (children and youth)	224	12	1.0	95%
Children's Boarding Homes	1,054	90	no direct funding by the Province	95%
Training Schools	1,302	13	19.7	Boys 75% Girls 93%
Juvenile Group Homes	240	32	2.0	85%
Residential Schools for the Blind and Deaf	1,372	4	10.8	63%
Juvenile Detention Centres	202	22	1.2	39%
Totals	<u>8,326</u>	<u>492</u>	<u>63.8</u>	---

TARGET GROUP 2 - CHILDREN AND YOUTH

	<u>Provincial Legislation</u>	<u>Ministry</u>
Children's Mental Health Centres	Mental Health Act, Children's Mental Health Centres Act Health Insurance Act	<u>HEALTH</u>
Children's Institutions	Children's Institutions Act	<u>COMSOC</u>
Charitable Institutions Youth and Unwed Mothers	Charitable Institutions Act	<u>COMSOC</u>
Children's Aid Societies Residential Facilities	Child Welfare Act	<u>COMSOC</u>
Homes for Retarded Persons (children and youth)	Homes for Retarded Persons Act	<u>COMSOC</u>
Children's Boarding Homes	Children's Boarding Homes Act	<u>COMSOC</u>
Training Schools	Training Schools Act (Federal Juvenile Delinquents Act)	<u>CORRECTIONS</u>
Juvenile Group Homes	Training Schools Act	<u>CORRECTIONS</u>
Residential Schools for the Blind and Deaf	Education Act	<u>EDUCATION</u>
Juvenile Detention Centres	Provincial Courts Act	<u>ATTORNEY GENERAL</u>

TARGET GROUP 2 - CHILDREN AND YOUTH

	<u>Provincial Centres of Administration</u>	<u>Ministry</u>
Children's Mental Health Centres	Institutional Health Services	<u>HEALTH</u>
Children's Institutions	Children's Services Bureau	<u>COMSOC</u>
Charitable Institutions Youth and Unwed Mothers	Children's Services Bureau	<u>COMSOC</u>
Children's Aid Societies Residential Facilities	Children's Services Bureau	<u>COMSOC</u>
Homes for Retarded Persons (children and youth)	Children's Services Bureau	<u>COMSOC</u>
Children's Boarding Homes	Children's Services Bureau	<u>COMSOC</u>
Training Schools	Juvenile Division	<u>CORRECTIONS</u>
Juvenile Group Homes	Group Homes Branch	<u>CORRECTIONS</u>
Residential Schools for the Blind and Deaf	Special Education Branch	<u>EDUCATION</u>
Juvenile Detention Centres	Assistant Deputy Attorney General - Administration	<u>ATTORNEY GENERAL</u>

ANALYSIS OF TARGET GROUP 2 - CHILDREN AND YOUTH

As may be seen from the previous charts this Target Group is represented by even more Ministries and administrative centres generating a deeper maze of philosophies, funding varieties, staffing patterns, standards and supervision.

Looking more closely at practice in the field whether in Health, Community and Social Services, Corrections, Education or Detention facilities, the child and youth population present a remarkably similar range of problems and behaviour patterns.

Though staffing patterns vary with financial resources, the front line units, i.e., the workers in closest contact with the children, have strong similarities in age, type of experience, attitudes, care terminology, behaviour and assessment criteria, methods of relating to children, etc., regardless of the setting, the auspices, or the theoretical framework.

When one sees many children and youth with much the same presenting behaviour, treated in much the same way, by a large variety of settings under numerous auspices, at costs varying from \$25. per diem to \$60. per diem and even much higher, the obvious question is how does one explain the difference.

In a recent study planned and commissioned by the Children's Mental Health Services Branch in the Ministry of Health which compared behaviour profiles of children in Community and Social Services facilities, Training Schools and Children's Mental Health Centres, the results showed no difference between the first two and only a slight difference for those in Training

Schools (see Bibliography, Ian Sone & Associates, Residential Care Study, Toronto, 1974).

In this respect it is interesting to note that our uncontrolled and unco-ordinated flow of admissions and lack of classification makes it a matter of chance whether a particular child will go to a children's aid group home at \$8 or \$9 a day - a Children's Institution at \$25 a day or a Children's Mental Health Centre at \$60 a day. After that he might go to Training School anyway at \$43 a day or a Correctional Services Group Home at \$18 a day.

Here again, this is not an argument for the elimination of high staff/child ratios in essential cases - but rather for a rational per diem allowance based on levels of care. This is already done. Corrections has four levels of care in the group home program from \$17 to \$30 and some Children's Boarding Homes have several levels. It is quite feasible to have six children in one home at three or four levels of care. This is in fact desirable since if you put all the most difficult clients together they would not likely "work" as a group.

Professionals argue against the reliability of predictions about how a child will fare in a particular setting. But any placing agency knows that the facilities quickly sort themselves out as to who can handle what kind of problem, and naturally enough, the children who can be contained by the fewest number of facilities should be accorded the highest per diem rate - and this happens now to some extent.

The main problem is that without generally accepted classification, and monitoring of admissions flow and control, it could easily happen - and

perhaps does - that a facility charging an overall rate of say \$45 per day has only about 1/3 of the children in it who should be accorded that level of care. We simply don't know. Most facilities select the children they want on an individual basis or perhaps it would be more accurate to say they try to keep out those that they don't want and let the rest in. The fact is that no systematic case audit of the children's facilities in Ontario has ever been done.

For a more detailed description of the programs see Appendix N in the Supplementary Appendices.

TARGET GROUP 3 - ADULTS IN CONFLICT WITH THE LAW

	<u>Beds</u>	<u>Facilities</u>	<u>Budget 74/75 \$ Millions</u>	<u>Utilization</u>
Jails and Detention Centres	2,731	43	20.9	80%
Adult Correctional Centres	2,910	11	30.8	78%
Community Resource Centres	127	12	.4	75%
Totals	<u>5,768</u>	<u>66</u>	<u>52.1</u>	---

TARGET GROUP 3 - ADULTS IN CONFLICT WITH THE LAW

Provincial Legislation

Jails and Detention Centres	Ministry of Correctional Services Act Prison and Reformatories Act
Adult Correctional Centres	Ministry of Correctional Services Act
Community Resource Centres	Ministry of Correctional Services Act

TARGET GROUP 3 - ADULTS IN CONFLICT WITH THE LAW

	<u>Provincial Centres of Administration</u>	<u>Ministry</u>
Jails and Detention Centres	Executive Director, Adult Programs	<u>CORRECTIONS</u>
Adult Correctional Centres	As above	As above
Community Resource Centres	As above	As above

ANALYSIS OF TARGET GROUP 3 - ADULTS IN CONFLICT WITH THE LAW

This Target Group is dissimilar in many respects when compared with Groups 1 and 2. It is of course a closed system with a much greater degree of control over its "clients". Furthermore, facilities and services are staffed almost entirely by Ministry personnel and governed by detailed, written standards and procedures. In effect it is a system in the sense that we recommended systems for the other two Target Groups. Classification and admission flow and control mechanisms are well developed, levels of "care" are cost related, and non-residential alternatives clearly defined and specifically applied on an individual basis.

This does not of course suggest that Correctional Services have no problems but that they can deal with them in a planned and systematic manner. Perhaps the comparison to the other Groups is not fair since the system is really imposed by the need for security and the protection of both public and prisoners alike. It is, however, a useful model for our purposes.

If the prophecy of The Honourable Warren Almand, Solicitor General of Canada, is fulfilled, the differences between this Group and the adults in Group 1 will be almost eliminated. In a recent public statement he said that the next twenty-five years would see the disappearance of prisons and parole as we know them today. They would be replaced by small regional institutions designed to provide individual rehabilitative treatment for law breakers. Already in Ontario we have the Temporary Absence Program and Community Resource Centres enabling prisoners to live and work much like other members of society. These together with

more imaginative uses of parole are rapidly moving what was not so long ago regarded as a rigidly intractable system into new directions. If the right to work is also extended to inmates inside the prisons themselves at reasonable wages as some Provinces are already considering, then more effective rehabilitation will have taken a great step forward. Prisoners will not only be able to pay their own way within the institutions to a degree but help their families and accumulate savings toward their return to the community.

For a more detailed description of the programs see Appendix N in the Supplementary Appendices.

ANALYSIS OF RESIDENTIAL SERVICE PROGRAMS

Mental Retardation Facilities I and II

These facilities were not included in the Target Groups since they serve the entire age range with a comprehensive residential program covering social, health and domiciliary needs. Diagram 1 shows their relationship to the three Target Groups. Since the introduction of the Developmental Services Act, 1974, provision has been made in Ontario for the development of a comprehensive residential, community and home support program for the retarded. Conceptually, it is an excellent model in itself for the other Target Groups.

For more detailed information see Appendix N in the Supplementary Appendices.

ANALYSIS OF RESIDENTIAL SERVICE PROGRAMS

Psychiatric Hospitals

This program provides a range of services to all age groups similar to the Mental Retardation Facilities and the same back-up support. It is also heavily involved in the development of community mental health services and engaged in an ongoing transfer of its responsibility for the mentally ill to active treatment hospitals.

For a detailed description see Appendix N in the Supplementary Appendices.

APPENDIX E

REPORT OF THE

INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

TRENDS IN GROWTH OF RESIDENTIAL SERVICES, 1970-1974

I. THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES

1.1. BED CAPACITY OF PROGRAMS (Note 1)

			1970	1974
(a) Mental Retardation Facilities, Schedule 1:	<u>Decrease</u> 4%	from	6539	to 6295 beds
(b) Mental Retardation Facilities, Schedule 2:	Increase 55%	from	498	to 775 beds
(c) Homes for Retarded Persons: (Note 2)	Increase 214%	from	217	to 681 beds
(d) Homes for Aged:	Increase 12%	from	23566	to 26300 beds
(e) Adult Group Homes: (Note 3)	Increase 70%	from	306	to 521 beds
(f) Children's Institutions:	Increase 35%	from	780	to 1056 beds
(g) Charitable Institutions (Youth and Unwed Mothers):	<u>Decrease</u> 11%	from	456	to 406 beds
(h) Children's Boarding Homes:	Increase 199%	from	367	to 1098 beds

1.2. UTILIZATION OF BED CAPACITY

(a) Mental Retardation Facilities, Schedule 1:	1970 1974 from 97% to 118%
(b) Mental Retardation Facilities, Schedule 2:	from 97% to 99%
(c) Homes for Retarded Persons: (steadily increasing over period)	from 80% to 95%
(d) Homes for Aged: (no discernible trend, Note 4)	from 80% to 93%
(e) Adult Group Homes: (no discernible trend)	from 65% to 72%
(f) Children's Institutions: (no discernible trend)	from 74% to 80%
(g) Charitable Institutions (Youth and Unwed Mothers); (decreasing over period, Note 5)	from 79% to 66%
(h) Children's Boarding Homes: (No statistics on utilization or per diem costs available)	

1.3. PER DIEM COSTS (Notes 6,7)

		1970	1974
(a) Mental Retardation Facilities, Schedule 1:	Increase 88%	from \$17.79	to \$33.50
(b) Mental Retardation Facilities, Schedule 2:	Increase 63%	from \$14.86	to \$24.15
(c) Homes for Retarded Persons:	Increase 48%	from \$11.84	to \$17.55
(d) Homes for Aged: (Note 8)	Increase 44%	from \$ 9.35	to \$13.50
(e) Adult Group Homes: (Note 8)	Increase 18%	from \$11.61	to \$13.74
(f) Children's Institutions:	Increase 44%	from \$15.80	to \$22.78
(g) Charitable Institutions (Youth and Unwed Mothers) (Note 8)	Increase 57%	from \$ 8.49	to \$13.29

II. THE MINISTRY OF HEALTH

2.1. BED CAPACITY OF PROGRAMS (Note 1)

	1970	1974
(a) Chronic Care Hospitals:	3220	3220 beds
(b) Private Chronic Care Hospitals: <u>Decrease</u> 14% from 500 to steady decline		430 beds
(c) Psychiatric Hospitals: <u>Decrease</u> 24% from 11145 to steady decline (Note 9)		8511 beds
(d) Nursing Homes:	Increase 20% from 19132 to	22875 beds
(e) Homes for Special Care: (Residential)	Increase 25% from 1600 to	2000 beds
(f) Children's Mental Health Centres:	Increase 18% from 753 to	920 beds
	(does not include units in psychiatric Hospitals)	

2.3. PER DIEM COSTS (Notes 6,7)

		1970	1974
(a) Chronic Care Hospitals:	Increase 37%	from \$26.70	to \$36.70
(b) Private Chronic Care Hospitals:	Increase 56%	from \$15.36	to \$24.00
(c) Psychiatric Hospitals:	Increase 99%	from \$25.16	to \$49.96
(d) Nursing Homes:	Increase 36%	from \$12.50 (1972)	to \$17.00 (1974)
(e) Homes for Special Care: (Residential)	Increase 50%	from \$ 5.00	to \$ 7.50
(f) Children's Mental Health Centres:	No information available.		

2.2. UTILIZATION OF BED CAPACITY

	1970	1974
(a) Chronic Care Hospitals:	from 90%	to 97%
(b) Private Chronic Care Hospitals:	from 96%	to 101%
(c) Psychiatric Hospitals: steady decline (Note 10)	from 82%	to 69%
(d) Nursing Homes: 90% in both years (1972,1973) for which statistics are available (Note 4)		
(e) Homes for Special Care (Residential): (Note 4)	from 91%	to 97%
(f) Children's Mental Health Centres:	No statistics on utilization available.	

III. THE MINISTRY OF CORRECTIONAL SERVICES

3.1. BED CAPACITY OF PROGRAMS (Note 1)

		1970	1974
(a) Jails and Detention Centres: (Note 11)	Increase 6%	from 2587	to 2731 beds
(b) Adult Correctional Centres: steady decline (Note 11)	<u>Decrease</u> 18%	from 3552	to 2910 beds
(c) Community Resource Centres: Commenced operation in 1974 with 127 beds			
(d) Training Schools: (Note 12)	<u>Decrease</u> 17%	from 1563	to 1302 beds
(e) Juvenile Group Homes:	Increase 200%	from 80	to 240 beds (1972)

3.2. UTILIZATION OF BED CAPACITY

	1970	1974
(a) Jails and Detention Centres: (Note 10)	from 71% to 80%	
(b) Adult Correctional Centres: (Note 10)	from 72% to 79%	
(c) Community Resource Centres: 75% in one year of operation		
(d) Training Schools: (Note 10)	from 77% to 87%	
(e) Juvenile Group Homes: steady increase	from 66% to 85%	

3.3. PER DIEM COSTS (Notes 6,7)

	1970	1974
(a) Jails and Detention Centres:	Increase 86% from \$15.26 to \$28.43	
(b) Adult Correctional Centres:	Increase 62% from \$18.26 to \$29.68	
(c) Community Resource Centres:	\$18.00 in one year of operation	
(d) Training Schools:	Increase 58% from \$26.95 to \$42.65	
(e) Juvenile Group Homes:	Increase 35% from \$14.50 to \$19.50	

IV. THE MINISTRY OF EDUCATION, RESIDENTIAL SCHOOLS FOR THE BLIND AND DEAF

4.1. BED CAPACITY OF PROGRAM:

Increase 18%, from 1125 in 1970 to 1325 in 1974. (Note 1)

4.2. UTILIZATION OF BED CAPACITY:

68% in 1973, 63% in 1974 (statistics for previous years not readily available) (Note 10)

4.3. PER DIEM COSTS:

Increase 47%, from \$28.57 in 1970 to \$41.94 in 1974.

V. THE MINISTRY OF THE ATTORNEY GENERAL, JUVENILE DETENTION CENTRES
Statistics not available prior to 1974.

NOTES

1. In considering changes in the capacities of the various facilities, it might be helpful to keep in mind that the population of Ontario gradually increased by 7.2%, from 7,551,000 in 1970 to 8,094,000 in 1974.
2. During this period the government adopted a policy of moving the mentally retarded from large institutions to community residences.
3. The unusually large increase in Adult Group Homes is a result of government policy to encourage the establishment of halfway houses for the rehabilitation of alcoholics.
4. Since older people are more liable to sickness and hospitalization, thus moving in and out of institutions, a rate of utilization of 90% or more possibly indicates that an institution serving such residents is operating at full capacity.
5. The use of homes for unwed mothers has sharply declined due in part to a wider use of aids to birth control, easier access to abortion, and changing standards which enables society to accept the unwed mother in the community.
6. In considering the increases in the costs of operating all the residential services, it is interesting to bear in mind that the cost of living in Canada steadily rose over this period by 35%, from an index of 129.8 to one of 175.8.

7. It is inappropriate to compare the per diem costs of the various facilities since they all have different methods of calculating the rate. The Report has recommended standard financial reporting to overcome this problem.
8. Homes for youth and unwed mothers, adult group homes, and some homes for the aged are governed by The Charitable Institutions Act which imposes a ceiling on per diem costs eligible for subsidy. Consequently such institutions tend to limit their programs and staffing patterns in order to keep to a minimum any costs over the ceiling.
9. The contemporary philosophy of treatment of the mentally ill encourages their removal from mental hospitals to active treatment hospitals and other community facilities.
10. Because certain institutions, such as correctional institutions, psychiatric hospitals, and residential schools for afflicted children, must make room for every person committed to them or eligible to attend them, it is normal for them to maintain a lower rate of utilization to accommodate peak volumes.
11. The Ministry of Correctional Services through its Temporary Absence Program has adopted a policy of placing adult offenders in employment and living facilities in the community, and this has had some effect on the capacity of adult institutions. Other factors have been the Bail Reform Act, intermittent sentences, more flexibility in the payment of fines, and increased use of probation.
12. By the establishment of its assessment centre for juveniles, the Ministry of Correctional Services has been able in many cases to

bypass training schools and to place children directly into children's institutions, children's boarding homes, and children's mental health centres, as well as into its own system of juvenile group homes. This, along with increased use of probation, has affected the capacity of training schools.

APPENDIX 8

A REVIEW OF RESIDENTIAL CARE FACILITIES FOR
CHILDREN AND YOUTH IN ONTARIO

by Edward Magder

November 1974

Ministry of Community and Social Services

A Review of Residential Care Facilities for
Children and Youth in Ontario

E. Magder, November 1974

Summary of Major Issues

1. Similarity of Services at Point of Delivery.
2. Differences in Per Diem Costs.
3. Control of Admissions.
4. Co-ordination of Placements for More Efficient Use of Facilities.
5. Funding and Provincial Administration.
6. Private vs Quasi-Public and Public Facilities.
7. Community Acceptance and Co-operation.

A REVIEW OF RESIDENTIAL CARE FACILITIES
FOR CHILDREN AND YOUTH IN ONTARIO

INTRODUCTION

This report describes a comparative review of residential care facilities made in the field between May and October of 1974. The gathering of financial and statistical data was part of the project plan but these were not available in time for inclusion. For that reason the report must be regarded as incomplete. The financial and statistical data were intended as complementary to the program information, the two together forming a basis for comparison of similar facilities. Having said that, it would appear that some of the implications arising from the review were sufficiently clear cut to deserve consideration on their own merit, and that was the justification for submitting the report in its present state.

No attempt was made to systematize the information gathered as a piece of formal research and definite conclusions were therefore not drawn from the findings; they were presented rather as issues with supporting commentary.

Visits were made to 63 of 225 facilities and approximately 200 staff were interviewed. Discussions were also held with placement staff of some of the largest user agencies and personnel were consulted in the Ministries of Health, Community and Social Services, Correctional Services and the Attorney General. The sample was selected on the advice of program managers in the above four Ministries and included facilities through the range of size, program sophistication, resources, philosophy and geographic location, serving emotionally disturbed, socially maladjusted, retarded and delinquent children and youth. As far as possible the information was factual and descriptive. No formal evaluation of program effectiveness was undertaken.

The review began under the auspices of the Committee on Group Homes chaired by Mr. Dave Jackson of the Management Board Secretariat. That Committee was dissolved in September of 1974 and its responsibilities transferred to the Inter-ministry Committee on Residential Services chaired by Mr. John G. Anderson, Assistant Deputy Minister, Delivery, Ministry of Community and Social Services. This report was therefore submitted to Mr. Anderson for consideration by the Interministry Committee.

The report was divided into the following main parts:

1. The Nature of the Services;
2. Organizational Characteristics of the Services;
3. Characteristics of the Resident Population;
4. Issues and Commentary.

PART 1. THE NATURE OF THE SERVICES

For the purposes of this report residential service was simply defined as a substitute or temporary home whose function was to modify the behaviour and attitudes of the residents and their families toward more successful living. A few of the facilities in the sample were beginning to serve children and their families in their own homes but this function could not be considered an established feature. It was nevertheless seen to be of vital importance by practitioners.

No distinction was made in the report between care and treatment. In the skill-resources-philosophy triad of each facility, no specific mix emerged that could be labelled care or treatment except for five Children's Institutions serving normal children and youth and there may be some question about the need for these services. The majority of practitioners interviewed agreed about the difficulty of differentiating care and treatment but thought the matter was not too significant. Comment on this point did, however, suggest avoidance of the mental illness concept for all but a very small number of residents.

Certain conditions which were assumed by practitioners to be general knowledge, but may not have been well understood by other professionals and the general public, appeared worthy of special consideration.

1. A great deal of thought and effort and many years of research has failed to produce an acceptable technique for measuring the results of residential services dealing with psycho-social problems. There has also been a number of major studies "proving" that psycho-social problems were largely unaffected by treatment, i.e. residential services, and these studies too were in question as to the validity of the measurement techniques used. Subjective reports of behaviour changes by staff, parents, teachers, relatives, friends, persons in the general community, professional consultants and the residents themselves, continued to be the sources from which judgements about "success" or "failure" were drawn.
2. Notwithstanding the above, the concept of program effectiveness did have meaning for staff, residents and others associated with residential care. While it may have been difficult to achieve general agreement about the specifics of the concept, a major ingredient was certainly the quality of human relationships within a given residence. When the tone of the relationships was negative, there was noticeable deterioration in the behaviour of the residents. Where the needs of both residents and staff were met up to an acceptable point, there was likely to be a positive attitude toward program effectiveness.

3. Nearly all practitioners agreed that modern methods of caring for children and youth in residential settings made great demands on staff, emotionally and physically. Commitment of staff was therefore regarded as a vital factor in program effectiveness and numbers alone could not compensate for its absence.
4. Finally, it was understood that chance played a large part in the choice of a specific facility for placement. Considerations such as cost, varying professional recommendations, availability of beds/admission requirements, geographic location, age and sex of applicant, and personal preferences of both placing agencies and applicants, often narrowed the field to one facility or resulted in placement delays - even though there might have been empty beds in some locations. Contrarily, practitioners were not prepared to guarantee better results in first choice facilities. For practical purposes, then, a very broad range of facilities might be used almost interchangeably to serve children and youth. The major exception was in work with the trainable retarded. Facilities were labelled for this purpose and admitted primarily those children and youth identified as mentally retarded, though in many cases it was very difficult to separate retardation and behaviour problems. Despite this specialization, service similarities between these facilities and all others for children and youth were striking, particularly in the methods used by front line staff in their interactions with residents.

The apparent consistency of practice found by the review, regardless of the variations in stated objectives of the services, was paralleled by a marked trend toward small family-type units located in residential neighbourhoods and rural settings. Even where facilities were centralized and established on easily identified locations, the use of the unit or cottage system was almost universal. Practitioners also appeared to be in agreement with the move away from purpose built facilities housing more than 10 residents in each unit and generally favoured the use of existing family residences housing 6-8 residents. The fact that this approach spread residents far and wide throughout communities in normal rather than institutional settings was regarded as a major therapeutic advantage. A high value was also placed on the independent functioning of the staff/resident unit not only as a means of confronting unacceptable behaviours in a natural life style, but in helping the residents learn the living skills essential to their future independence. The rejection of institutional living in favour of normalized living confirmed the fact that the style of life in our society was based on the family, and any residential service, especially one for children and youth, should recognize that fact and help prepare the resident to live within it.

Supporting this trend were recent policy decisions made by the Ministries of Community and Social Services and Correctional Services to continue the development of small community based residences for the retarded and for juvenile delinquents. In both cases, the Ministries were committed to phasing down the existing congregate institutions. Beyond facilities for the retarded and juvenile delinquents, services for the emotionally disturbed and socially maladjusted under the Ministries of Health and Community and Social Services were already far advanced in this direction. Thus, while there might always be a need to maintain some institutions for the small minority who could not be contained in more open facilities, the dominant style for most residential services was likely to be the community based family-type home. (Family-type refers to homes with 6-8 residents staffed either by houseparents or child care workers on shifts, or a combination of both, who live together in a family life style.)

There has always been neighbourhood and municipal opposition to the establishment of community based residences and indeed to institutions. Understandable, though largely uninformed concerns about personal safety, property damage and property values were the reasons generally given. The parents of some children and youth served by the facilities have also expressed concern about open, decentralized facilities, in the belief that closed facilities gave better and safer service. Some even preferred their offspring to be locked away. However, a decade or more of experience with both types of care has shown all of these concerns to be much exaggerated or groundless. In fact, communities and neighbourhoods hosting established family-type residences expressed much more positive than negative attitudes toward them.

On the matter of cost, it has been mistakenly assumed, under the influence of business thinking, that economies of size applied to all forms of residential care. In practice, small facilities for children and youth have proven less costly to operate, and in a considerable number of instances, the margin was very wide indeed. For once economy and professional preference appeared to coincide. In discussions held with 200 front line staff, placement agencies and government officials, there was overwhelming support for the small unit approach. Reference to the rationale for this has already been made but it might be well to consider some of the arguments in more detail.

Whether children and youth live in their own homes or substitute homes, they all need to be involved in a learning sense in the development of appropriate emotional responses, acceptable one-to-one and group relationships, relatedness to community activities and social values, and basic cognitive and motor skills. These "learning needs" are met in order to build the foundation of satisfactory

adult and family living. Where the learning process is disrupted by impaired family function or complete family breakdown, it seems reasonable to provide a healthy substitute of the same nature. Why not, then, simply place the child in a normal home? It is argued that the unacceptable responses he has learned as a result of the impaired functioning of his own family must now be "unlearned" and acceptable responses "relearned" and most normal families cannot sustain the rigorous demands of this process without professional guidance, support and relief. Furthermore, the risks of failure are serious since each successive move tends to enforce the negative patterns already learned and erodes the trust and security in relationships with adults which children need for successful maturation.

The family-type service is set up to provide the appropriate learning and safeguard the child's need for trust and security. Appropriate learning goes on through participation in family-type activities: shopping for groceries and clothing, preparation of meals, household chores, care of appliances and equipment, care of pets and domestic animals, discussions about attitudes toward drugs and alcohol and boy-girl relations, appropriate expressions of affection and anger, etc. Through these activities opportunities for developing positive relationships with adults and peers are constantly posed and unacceptable behaviour and attitudes confronted. In institutions, with numerous staff and the necessary hierarchies, many of these real life experiences are pre-empted or seriously hampered by the demands of large-scale administration.

The argument follows, then, that any residential program for children and youth should continue the vital process of psycho-social learning inherent in the healthy family. This does not deny the need for individual counselling or indeed any useful support from within or without the residential service. But more and more such assistance focuses upon the day-to-day give and take of family-type activities. Essentially, the process involves repetition and reinforcement of acceptable responses, avoidance and negation of unacceptable responses and helping the resident to understand the logic of these choices and the attitudes supporting them. It is said that this process takes place more effectively in the family-type setting, the mode that brings us closest to the real world of the child or adolescent and eventually to the real world of the adult.

Whether or not children and youth return to their own homes following residential care, there was a growing belief that involvement with the biological family, however minimal, was beneficial. More emphasis was consequently placed on work with families and there was

a concurrent trend toward working with children and youth in their own homes. This was formerly seen as the almost exclusive function of children's aid and family service agencies but some practitioners believed that child care workers with residential service experience had an important contribution to make. This approach was in the early stages of development in a few facilities.

In summary then, there appeared to be two basic forms of residential services for children and youth: the centralized "purpose built" facility with relatively heavy administration, and the small, more autonomous neighbourhood and rural family-type setting. The organizational distinction between the two was not always clear since quite large facilities might be composed of small, relatively autonomous, family-type units, and centralized, purpose built facilities might use cottages or units to house the residents. The significant difference was in the specific day-to-day program activities and living styles. The general view of the practitioner strongly favoured the family-type service with small, specialized institutions used only for the most serious behavioural and emotional problems.

PART 2. ORGANIZATIONAL CHARACTERISTICS OF THE SERVICES

Procedure in this part of the review involved interviews of about 2½ to 5 hours with the Director and in some cases other senior program staff. The purpose was to provide a comprehensive description of the organization and its day-to-day operations. An outline guide was used in each case and a record was kept of the information. The items included below indicate the scope and direction of the review.

Guide to Questions about Organizational Characteristics

- 2.1. Admissions - number of beds; age and sex of residents; average length of stay; admission requirements and procedures; role of referral agencies; involvement of close relatives; specific categories excluded.
- 2.2. Activities - typical day of summer and winter programming; evening and week-end activities; formal education on-campus and in the community; homework; extra curricular school activities; home visits, visits to friends, relatives, agency staff; use of

community recreation and other facilities; counselling of residents and families; program philosophy, methodology, planning and input by residents and line staff.

- 2.3. Staffing - numbers and functions of staff, deployment, qualifications, special skills, salaries, age range; staff meetings, in-service training and other training; length and kind of previous experience; delegation of authority; staff commitment; staff problems and turnover; part-time staff, special consultants and volunteers.
- 2.4. Discipline and Controls - expectations for residents; rules: staff imposed and resident imposed; direct participation of residents in maintaining discipline and controls; consequences of unacceptable behaviour; rewards; spending allowances; meals and bedtime; household chores; care of facility: furniture, equipment, clothing; use of drugs and alcohol; sex; infringements of the law, use of courts and police.
- 2.5. Independence and Self Reliance - progressive development of responsibility and leadership; personal hygiene and grooming; assistance to staff and support of program; volunteer work and part-time jobs; friendships; household chores; care of facility.
- 2.6. Physical Plant, Facilities and Equipment - proximity of appropriate schools, health, recreation and other facilities; natural environment; arrangement of bedrooms, bathrooms, dining rooms, recreation rooms and lounges; gymnasias; swimming pools, skating rinks, sports grounds; lakes and streams; furniture and decor; vehicles, bicycles, snowmobiles, go-carts; grounds and farm equipment.
- 2.7. Funding - government contributions at all levels, capital and operating, ongoing and one-time; private fund raising; fees from placing agencies and parents; united appeals; gifts and legacies.
- 2.8. Feedback - comments from residents and staff about any aspect of specific facility or children's and youth services in general.

It should be noted that all the facilities in the sample had a great many organizational characteristics in common. It also became evident as the review progressed that day-to-day programming and administration followed much the same pattern. It was therefore feasible to cross check points at issue from facility to facility and there was a remarkable consistency in most of the significant areas of concern.

PART 3. CHARACTERISTICS OF THE RESIDENT POPULATION

Procedures followed in this part of the review were similar to those in Part 2. About 200 front line staff were interviewed about the group of residents they knew best. Each staff member was told about the role of the reviewer and the information already acquired from the Director of the facility. About 1½ to 2 hours was spent with each staff member. The items used in the question guide are shown below. The list is not complete but does indicate the scope and direction of the review.

Guide to Questions about Characteristics of the Residents

- 3.1. Background and Referral - age, sex, length of stay in residence; source and circumstances of referral; family background; previous involvement with children's aid, courts, police, training school, other residential facilities; histories: medical, psychiatric, psychological, psychometric, social work; behaviours: family, school, community, other facilities; major reasons for placement.
- 3.2. Experience in Residence - description of behaviour after admission, after settling in; response to program; special problems; behaviour changes over period in residence; relationships: staff, peers, teachers, own family members; level of function, emotional and intellectual; understanding and insight; ability to accept responsibility, to give and accept affection; school and work performance; social attitudes; friendships; personality and appearance; special skills, recreation interests; sexual behaviour; infringements of the law; dangerous behaviour.
- 3.3. Planning for Residents - individualized programming; participation of parents, relatives, friends, interested agencies; family and other outside visits; behaviour contracts; direct focus on specific problems; resident's participation in planning: understanding and acceptance of individual objectives related to home, school, work, community.

It should be noted that each resident in the sample was discussed separately and the results recorded. Obviously much of the same ground was covered in questions about the organizational characteristics and the characteristics of the residents. In the case of the organization, the focus was on overall programming and in the case of the residents, how the programming affected each individual resident. The two together gave a fairly complete picture of total day-to-day operations.

Again, there was remarkable consistency in the characteristics of the population from service to service. The range of differences in individual treatment was narrow and the similarities striking. In this connection it should be said that all staff interviewed were almost without exception courteous and co-operative and discussion appeared free and open. Furthermore, the views expressed appeared to be independent and individual; nearly all at some time or other during the interview indicated that opinions were personal and might not agree with those of other staff or "official policy". Where facilities were too large to interview all front line staff, a significant sample was selected. Evaluative comments were not solicited although they were frequently made and they were rarely overly critical or defensive. As a result of staff turnover in the field, many of the Directors and front line staff had working experience in a number of different settings.

PART 4. ISSUES AND COMMENTARY

As indicated earlier the planned financial comparisons from service to service and category to category were not undertaken in time to be included in this report. The following issues and commentary do, however, make some references to funding where they appear to have a direct bearing on service comparisons and do not require detailed financial analyses.

4.1. Variety of Residential Services

It has been generally assumed that the effect of residential service on the residents is basically achieved through the interactions of the total staff/resident group. The efforts of the staff in all cases was toward helping the residents practise more successful responses to the human and material environment and to understand the need for behaviour changes for both present and future success. Detailed practice and program used by front line staff tended to follow a similar pattern in all facilities. Furthermore, the characteristics of the staff and the population throughout, except for small groups at either extreme of the continuum, appeared almost identical. It is therefore pertinent to consider whether present categories of service are appropriate in the Ministries of Community and Social Services, Health, Corrections and the Attorney General, including the inherent

funding and administrative variations. This consideration was basic to many of the issues arising from the review.

4.2. Staffing

Differences in staff ratios were almost wholly responsible for the variations in cost. Where staff ratios were high the staff was almost invariably young, generally inexperienced and often untrained, with older, more experienced supervisors. Where staff ratios were lower, staff tended to include older persons who had more experience and who had proven ability in working with children and youth. However, in both cases, actual staff hours spent with the residents did not adequately reflect differences in ratios. Put more simply, there was a tendency for the same number of staff to be working directly with the residents at any given time regardless of the size of overall staff. Staff in high ratio services appeared to have more time off and engage in more activities not directly involving the residents, e.g. administration, supervision, meetings, etc. Finally, reported program effectiveness did not appear to be related to staff ratios.

4.3. Admissions Control

A common complaint from practitioners was that the services with the greatest resources had the widest freedom of choice on admissions and those with the least resources had much less choice. Children's Mental Health Centres with 100% funding for example, were in the position of balancing their workload as they chose. The services with the least number of staff, i.e. Children's Boarding Homes had to accept children referred to them by Children's Aid Societies, Correctional Services and Courts, upon whom their total revenue depended. This was said to result in many services having a heavier workload of difficult children than others while at the same time having fewer staff. Children's Aid Societies and Correctional Services also complained that it was becoming more and more difficult to place their wards in Children's Mental Health Centres and that actual numbers had decreased markedly over the past few years. The review tended to support these claims but since records on admissions are unevenly and inadequately kept by the Ministries, it is difficult to document actual practice.

4.4. Co-ordination of Placements

Many practitioners believed, partly for the reasons given in 4.3., that central planning for placements had to be established in order to properly utilize the available facilities. The review showed a significant number of residents, about 20%, who, in the opinion of Directors and front line staff, did not require the service at all or might more appropriately have been placed in some other facility. Since nearly all the facilities had completely independent admission policies and procedures, this was not surprising.

4.5. Funding in Practice

Although the resident population and the service programs were relatively homogeneous, per diem costs varied radically. For most of the population the range was from \$25. to \$60. but there were much more extreme individual examples. However, since there were no standard financial or statistical reports available, the variations might have been somewhat greater or less than they appeared. Methods of funding and financial control also varied from authority to authority and this heavily influenced choices made by the users of service. Programs funded 100% by the Province were free to users and tended to be first choice placements whether or not they were appropriate. (Children's Mental Health Centres, Institutions for the Retarded.) As a result there was great pressure on these services to expand while those requiring a fee to be paid might have empty beds. Children's Aid Societies and Correctional Services, by far the greatest users of the services, are under considerable financial constraints and thus try to place as many wards as possible in the free facilities. Since these children and youth are likely to be the more difficult group, placements are hard to find. One result has been the large scale development of parallel services, particularly in Children's Aid Societies.

4.6. Geographic Location

The cost of land has probably been the single most influential factor in determining location of services but also important have been zoning restrictions, particularly in the past few years, with the coincidence of urban expansion and rapid growth of residential facilities. One exception to this has been the establishment of group homes by Children's Aid Societies who have had less difficulty with zoning problems. Location of facilities in recent years has

thus tended to concentrate in and around small communities on the fringes of the large urban centres, particularly in the London, Kitchener-Waterloo, Cambridge, Toronto and Oshawa areas. Proximity to schools able and willing to accept children in special teaching programs has become an increasingly important factor.* As might be expected, there has been growing resistance by smaller communities to continuing expansion of residential facilities.

4.7. Staff Training

There was widespread dissatisfaction with staff trained in child care courses who applied for front line positions. This was ascribed to high expectations of such staff especially in matters of pay and job definition. As indicated earlier, the job of most front line staff may involve some preparation of food, household chores, shopping, personal care and hygiene tasks, etc. There was a feeling that trained child care staff were much less prepared to do this kind of work; they preferred the counselling side of the job. They also tended to be more critical of established practices and to insist on regular working hours. This was resented by more experienced staff. A number of directors preferred to hire BA graduates with little or no experience and provide the training themselves. Another feature of staffing was the remarkable success of a number of gifted "amateurs" in this field. In nearly all the facilities visited there was at least one, sometimes more, front line or supervisory staff, with little formal education who came into the work by chance and proved to be outstanding in their devotion to, and success with, the residents. In many facilities this natural ability with children had priority in recruiting over formal education and experience.

4.8. Private vs Quasi-Public and Public Facilities

There has been much public discussion about profit-making enterprises in the field of residential services. Most of the criticism came from the uninformed public and certain professionals who believed that making a profit out of this work was suspect. However, the user agencies who placed children and youth in the private services administered under the operating Ministries, Community and Social Services, Health, Correctional Services and the Attorney General, are

* For a more detailed discussion on this point see "The Education of Children and Youth in Residential Facilities Approved by the Ministry of Community and Social Services" by E. Mugder and P. Wiseman, November, 1974.

more than satisfied with them. All things considered the private services visited in the course of this review appeared no less effective than the public and quasi-public services and in some cases appeared moreso. Striking differences were in expenditures on buildings. Private services used existing family dwellings almost exclusively while quasi-public and public services tended to use purpose-built facilities. Furthermore, where private facilities operated on a fee for service basis, per diem costs were at the low end of the scale.

4.9. Innovation

Congruent with contemporary social change and experimentation, residential services have placed more emphasis on the rights and responsibilities of the residents, greater involvement between staff and residents and general integration with community life and supporting services. The old self-help concept has been dusted off and dressed up in modern styles and the primacy of familial love and closeness reaffirmed. This has led to a new appreciation of the meaning of the family to children and youth. The relationship to the biological family appeared to be a more vital source of identity even when the relationship itself was not a positive one. Practitioners were advocating more direct work with families in helping them to restructure relationships rather than removing the child, and to this end might place child care staff directly in the home. Short of that families were being involved more closely with their children in residences in bringing about change and eventual reunion wherever appropriate. Apart from increasing work with children and youth in their own homes, innovation in residential services has already been well established.

4.10. Proposed Service Change

There were five residences under The Children's Institutions Act serving about 200 normal children in Toronto, London, Ottawa and Sudbury. The children were largely from homes whose parents were in difficulty through illness, marital or financial problems and it might have been more appropriate for them to be placed in temporary foster care in Children's Aid Societies. If further investigation supports this alternative, then the residences could be closed or converted to more urgent uses such as services for retarded children.

4.11. Community Acceptance and Co-operation

Zoning has already been mentioned as a problem in the location and development of community based residential services but this was only one aspect of broader public resistance exemplified by the complaints of ratepayers groups, municipal officials and boards of education. It appeared that these problems were generally related to public confidence in the supervision of the children and youth in the residences and also the overall supervision of services by responsible government agencies. Both level of government staffing and public relations were pertinent. One suggestion was that representatives of ratepayers groups be invited to sit on residential service boards or be involved in some other way.

4.12. Amendment to the Training Schools Act

The proposed amendment to repeal Section 8 of the Training Schools Act, if approved, would place heavier demands upon existing residential service facilities. Figures suggested that the change might divert about 400 children each year from training schools to Children's Aid Societies who would then have to find or develop appropriate facilities for their care.*

* For more detailed discussion see Cabinet Submission of October 28th, 1974 made by the Ministries of Health, Community and Social Services and Correctional Services on the implications of the repeal of Section 8.

APPENDIX G

REPORT OF THE INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES
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APPENDIX H

PROVINCIAL RESIDENTIAL PROGRAM SUMMARIES 1974

[illegible]

REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

SUPPLEMENTARY APPENDICES

APRIL, 1975

PROVINCE OF ONTARIO

SUPPLEMENTARY APPENDICES

REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

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APPENDIX I

PROPOSAL TO ESTABLISH
THE INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

AUGUST 13, 1974

1. THE PROBLEM:

To establish an Interministerial Committee which would bring together and coordinate the relevant data concerning all forms of residential care and to make policy recommendations in regard to them, including categorization, divisions of responsibility, relevant costs and manner of financing.

2. BACKGROUND:

Discussions at the Provincial/Municipal Liaison Committee level for some time, have revolved around the funding formulae in operation, relative to the cost of care in nursing homes, municipal homes for the aged, and charitable institutions, as they dealt with residents who were normal, ambulatory retired persons, intermediate care residents or extended care patients.

The introduction of the GAINS Program and the tax credits programs, with allowances provided by the Government of Ontario, further identified the problem of paying allowances or benefits to some groups of persons who were already receiving total or near total maintenance in government supported residential institutions.

As attempts were made to provide equity to these groups of elderly or infirm persons, further questions surfaced which had been inadequately dealt with in the past.

A small interministry committee of Health and Community and Social Services, formed basically to deal with the

rate differences between extended care and residential care, began to receive a wide range of referrals relative to the whole question of institutional or long-term residential care.

At the same time, other interministry groups have attempted to rationalize categories and funding of various other types of institutional facilities such as group homes, treatment centres and the like. The valuable information that has been thus collected requires correlation with all other documentation.

It became obvious that there is an overall need to look into the financing and operating policies of a range of facilities that goes well beyond the care of the aged.

3. PROPOSAL:

It is suggested that an Interministry Committee be established to conduct a study which would include all long-term facilities where, beyond the needs and cost of health, or treatment, or supervision, or guardianship, there is a provision of the every day maintenance needs of the individual in care.

It has been a principle of the health insurance program that long-term medical care (chronic hospitals, extended care) should not be financially crippling to an individual or to his or her family. On the other hand, it is hardly equitable that while total costs are covered for one individual with a certain level of handicap, another resident

of the same institution receiving less care may pay higher rates from personal funds, or have property encumbered to compensate the operators.

In another field, it would seem desirable that the facilities for the mentally retarded arrive at a uniform funding formula for parental responsibility, to ensure that no financial bias is operative in choosing the most suitable placement for the retarded person.

Similarly, it does not seem reasonable to limit provincial support at a lesser percentage of the cost of operation in connection with a preventive institution (group home) and then assume full cost of similar facilities in a remedial or custodial capacity (correction group home).

It is assumed that the work of the proposed Committee would cover at least the following areas of care: chronic care in general hospitals, chronic hospitals, nursing homes, homes for the aged, charitable institutions, psychiatric and retardation facilities, group homes for adults and children, long-term treatment centres, homes for special care and homes for retarded persons.

While the primary focus would be on facilities under the aegis of the Ministries of Health and Community and Social Services, it is expected that there would be a secondary involvement in the case of juveniles under the Ministry of Corrections or other agencies.

Specifically, it is proposed that:

(A) Terms of Reference:

Members of the Committee direct their attention to:

1. Definition of reference points on a continuum of "care services" (i.e. from little care to extensive care);
2. Definition of reference points on a continuum of "term of care" (i.e. from short term to long term);
3. Identification or categorization of the total consumer group for long-term institutional care;
4. Delineation of the range of services to be provided to each group;
5. Division of responsibility to provide or finance the various types of care or services, between personal, health or welfare levels;
6. Manner of providing financial support to the individual or institution for the levels of care required;
7. Rationalization of needs testing versus universality of care with regard to the various resident groups;
8. Policy proposals relative to the ratio of private versus government operation of institutional facilities;
9. Policy proposals to determine the relative Ministry responsibility for various categories of institutional care;

10. Identify and coordinate all pertinent and relative committees working in this area of care in the Ministries concerned.

(B) Committee Composition:

In view of the cooperative effort which seemed to develop in the implementation committee for the GAINS Program, and as much of the recognition of the Ministry inter-relationships in this area came from the members involved, it is recommended that the working committee be composed of:

J. Anderson	-	Community and Social Services
W. Henderson	-	Ministry of Health
M. Lagace	-	Social Development Secretariat
W. Powell	-	T.E.I.G.A.
D. Bogart	-	Management Board
N. Yurchuk	-	Ministry of Revenue

If these appointments are ratified, there should be a clear understanding particularly within Health and Community and Social Services that considerable staff involvement at a relatively senior level will be required for various aspects of the project as it proceeds.

Contribution to the Committee efforts should be solicited from various private sources and it is suggested that representation be obtained from the following private sources.

Advisory Group

- Ontario Association of Homes for the Aged
- Ontario Association of Nursing Home Operators
- Ontario Association for the Mentally Retarded
- Senior Citizen representation
- Prof. Nathan Markus, U of T School of Social Work
- Ontario Advisory Council on Ageing.

(C) Time Period:

It is proposed that the final report of the Committee be completed by April 1st, 1975.

(D) Staff Support and Costs:

It is proposed that the committee be serviced by an Executive Secretary together with a Research Coordinator and appropriate clerical support.

Six Months Costs of Study

Salaries (taken at mid range)


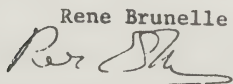
Executive Secretary (Exec. Officer II)	\$8,225
Secretary (Clerk-Typist 3)	3,456
Research Coordinator (Economist I)	4,621
Clerk (Clerk-Typist 2)	3,200
	<hr/> 19,502
Employee Benefits @ 12%	2,340
Travel	2,000
Supplies and Equipment	458
Services (research contract, advisory per/diems, printing, etc.)	25,700
TOTAL	<hr/> \$50,000 <hr/>

4. RECOMMENDATIONS

(A) That an Interministry Committee be established as proposed with the following terms of reference:

1. Definition of reference points on a continuum of "care services" (i.e. from little care to extensive care);
2. Definition of reference points on a continuum of "term of care" (i.e. from short term to long term);
3. Identification or categorization of the total consumer group for long-term institutional care;
4. Delineation of the range of services to be provided to each group;
5. Division of responsibility to provide or finance the various types of care or services, between personal, health or welfare levels;
6. Manner of providing financial support to the individual or institution for the levels of care required;
7. Rationalization of needs testing versus universality of care with regard to the various resident groups;
8. Policy proposals relative to the ratio of private versus government operation of institutional facilities;
9. Policy proposals to determine the relative Ministry responsibility for various categories of institutional care;

10. Identify and coordinate all pertinent and relative committees working in this area of care in the Ministries concerned.
- (B) That the Committee be authorized to consult with the proposed advisory groups and any other sources of information as deemed appropriate.
- (C) That the final report of the Committee be completed by April 1, 1975 and
- (D) The staff requirements and \$50,000 be authorized for the Ministry of Community and Social Services for the purposes of this study.
- (The Ministry requires no funds at the present time).


Rene Brunelle


13 August 1974

APPENDIX J
REPORT OF THE INTERMINISTRY COMMITTEE
ON RESIDENTIAL SERVICES

INTRODUCTION

The three Projects undertaken by the Committee as described below were designed to meet the Terms of Reference approved by Cabinet and also to encompass many of the implications arising from them. The Projects were not integral, in that Two and Three might be implemented without One, but they were broadly complementary.

PROJECT ONE

We proposed in Project One, a vehicle to produce three systems of residential facilities and corresponding non-residential alternatives, for Adults, Children and Youth, and Adults in Conflict with the Law, along the lines of natural growth and development that have already taken place. The existing mechanisms within Government arose to serve the needs of a much earlier technology and while the subsequent patches and repairs held for a time the rapid social and program developments of recent years now suggest the need for comprehensive changes.

The concepts behind the basic proposal in Project One are not new, dating back to the Report of the Seeborn Committee in England in 1969 and Canada's later CELDIC Report, to mention only two. We had the advantage of watching many attempts at reorganization that tried to achieve too much, too quickly. We believed our objectives to be vital but modest, and our method should allow testing and consolidation at each major step along

the way, without disrupting established organizations in the Ministries.

We also believed that the ground had been well prepared by a changing philosophy concerning service delivery methods in both the private and public sectors. We sensed that many of the early objections to integration and the fears of vested interests were later seen in the truer perspective of that earlier process. The people we talked to in this field appeared less concerned about government "interference" in the co-ordination of services and much more concerned about moderating the confusion and inconsistency that frustrated them at every turn. The private sector appeared more secure about its continuing importance in the service partnership and our scheme should further support that feeling with the provision we made for participation in planning, implementation and delivery.

PROJECT TWO

Project Two affirmed our belief in personal responsibility as a part of normal life experience. Past events have proven beyond doubt that "handouts" undermine the dignity and feeling of self-worth of the individual. Even though such "benefits" have been inescapable in many circumstances, and will no doubt continue for some time to come, the negative impact should be considered. We have therefore proposed the principle that residents, and parents of children in residences, share the cost of care, as they are able, by assuming that part related to normal living costs. To act on that principle with equity will require a great deal of ingenuity and careful planning because of the variety of circumstances involved. A flat charge across the board similar

to the coinsurance premium in Extended Care was attractive for its simplicity and ease of administration but it would leave many vexing problems unresolved. Here, too, we believed that we should address ourselves to broader and more basic issues.

PROJECT THREE

Project Three proposed a functional chart of accounts for standard cost comparisons in budget items from facility to facility. It was not intended to replace present accounting practises in the Ministries or the facilities, but rather to afford the capability of accurate cost comparison, of such great importance in planning and priorities at every level. The chart was prepared with the active participation of four of the five operating Ministries responsible for residential programs in the Province and the effect on procedures in the individual facilities was taken into account.

In summary then, we believed our recommendations to be consistent with the program and financial developments current in the field of residential services and that they would provide the organizational form to moderate the confusion, conflict and inefficiency deplored by the private and public sector alike. The proposals were designed to attempt this without changes in the existing structure of participating Ministries unless eventual experience provides convincing evidence of its necessity.

REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

SUMMARY

Based on the terms of reference in the proposal of August 13th, 1974, over the signature of The Honourable Rene Brunelle, (see Appendix I) the Committee divided its work into three projects which, together with the publications and documents in the Bibliography, provided the main body of information from which the report and recommendations were drawn.

PROJECT ONE

Twenty-three programs of residential services were identified in the Ministries of Health, Community and Social Services, Correctional Services, Education and the Attorney General, representing all the residential services funded wholly or in part, directly or indirectly, by the Province, excepting Active Treatment Hospitals. These appeared to be excluded by implication on page 4 of Mr. Brunelle's proposal. Although Adult Correctional Centres and Residential Schools for the Deaf and Blind were not specifically mentioned, it was decided to include them on the recommendation of the Committee. The programs were reviewed under eleven headings and summarized, then analysed individually and comparatively. (See Appendix N) . .

This analysis fully confirmed the many inconsistencies, conflicts and anomalies which stimulated the establishment of the Committee.

Four features of residential services in Ontario appeared to stand out: that the quality of service, and the supply of facilities were generally adequate to the purposes, though perhaps in some cases more than adequate and in other cases less; that appropriate utilization was hampered by poorly developed home and family support services which could provide better and less costly options; and that there was remarkable similarity of service modes both within and across three target population groups: Adults, Children and Youth and Adults in Conflict with the Law. This factor had important classification, cost and programming implications which will be discussed later in the report.

In specific detail the tasks facing the Province appeared as follows:

- to co-ordinate, integrate and monitor residential services;
- to consider alternative non-residential home and family support services;
- to eliminate or at least moderate anomalies, inconsistencies and conflicts, and to effect improvements in: philosophy, legislation, supervision and standards; admissions and length of stay; funding, cost control and Federal cost sharing;
- to consider the principle of financial responsibility of residents, and parents of child residents, with reference to basic needs;
- to systematize financial recoveries from residents and their discretionary income;
- to reveal service gaps and if and how to fill them; and
- to establish cost related levels of care for each of the three target groups.

All this and probably much more needed to be done in order to achieve more rational, efficient and accessible service with good value for the money spent.

Projects Two and Three represented specifics arising from Project One, although Project Two had been identified prior to the establishment of the Committee as a result of the work done in preparation for the GAINS program.

PROJECT TWO

This was a detailed study and analysis of present methods of financial recovery, and amounts recovered, from residents against the cost of their residential care. Also analysed were the residual funds left to be disposed of at their discretion, or, in some cases, of funds provided to them as allowances. Great inequities and irrational procedures were found to exist and it was agreed to establish a method or methods by which these might be eliminated or moderated according to the characteristics of each of the major target population groups: Adults, Children and Youth and Adults in Conflict with the Law.

PROJECT THREE

This project had as its objective to produce a chart of functional accounts through which standard financial reports could be produced by all residential services. This would enable accurate comparison of like costs from facility to facility and also of divisions within facilities. At the time very few methods of reporting in the 23 residential programs afforded this capability. If the Government was to give appropriate weight to cost factors in planning the future combination of services, both public and private, and make reliable cost/benefit judgements, then accurate cost comparison appeared to be an essential requirement.

Faced with this broad challenge in a period of four months working time, the Committee agreed to propose a further period of more intensive evaluation ending in the production of guide lines as shown in Diagram 2 on page 29. The guide lines would then be used as shown in Diagram 3 on page 30, both employing as frames of reference the target populations shown in Diagram 1, on page 24. The need for an approach of very broad scope appeared to the Committee to preclude other options and none were therefore offered. It did appear however, that the first stage (Diagram 2) could be completed in a relatively short time, say six months, without a commitment to the second stage (Diagram 3) until the experience of the first stage was assessed.

There were two major reasons for the broad scope of this proposal. One was the need for classification of persons in the target populations according to their needs and the corresponding cost-related classification of levels of service to meet them. The second reason was the need for improved control of admissions and the flow of persons through the various levels of service. There were other important considerations too, as detailed in the main text of the report, that indicated the need for the comprehensive and systematic proposals recommended by the Committee.

APPENDIX KKKKK

REPORT OF THE

INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

PROJECT ONE: THE BASIC PROPOSAL

The basic proposal arising from this study was that mechanisms be established to produce guide lines for, and implement, three integrated systems of residential facilities and alternative services, based on three target population groups: Adults, Children and Youth, and Adults in Conflict with the Law.

METHODOLOGY

Most reports of this kind include reference to total target populations from which there might be a demand for specific services. Because of the variables involved it was difficult to see how such gross numbers could contribute to the planning process.

Our approach, then, was to start with the current demand for residential services as it was in practice and to determine to what extent this demand was being met in broad terms. To round out the picture we also considered the demand for alternatives to residential services and how that was being met.

Demand obviously cannot be measured in absolute terms but some sense of it can be gained from relating it to the existing supply which is quite sensitive to public pressures. Further questions arose from this general base and they were set down in a format and used to collect information about the twenty-three residential programs in the Ministries

of Health, Community and Social Services, Correctional Services, Education and the Attorney General. (see detailed reports, Appendix N)

Most of the residential services for children and youth had already been reviewed by means of sampling in the field under the auspices of the former Committee on Group Homes. We have taken the liberty of including that report as Appendix F on page 78 of the main Report. The present Committee decided that enough information existed within the Ministries and in previously completed reports for the remaining programs without going further afield. Accordingly, the Provincial program managers and financial officers of the twenty-three residential programs were interviewed, the existing reports were read and the representatives of the facilities designated as the Advisory Group in the proposal on page seven of Appendix I were consulted. A report was written on each program, then an analysis was made of the reports as a whole and a summary chart was prepared (Appendices D on page 44 and H on page 100 of the main Report).

Active Treatment Hospitals were excluded in the proposal, and the Committee decided to exclude Chronic Care Units in Active Treatment Hospitals as well because they could not be separated from the active treatment sections for practical purposes. Adult Correctional Facilities and Residential Schools for the Blind and Deaf, although not specifically mentioned in Mr. Brunelle's proposal, were included by the Committee. A complete list of the programs is shown on the summary chart (Appendix H on page 100 of the main Report).

FINDINGS

The review of the twenty-three residential programs presented four broad aspects around which the findings were considered: quality, supply, utilization and similarity of needs and services.

QUALITY

In the past five years or so residential facilities have made substantial improvements in staff/resident ratios, qualifications of staff, range of services, recognition of the rights and dignity of residents, accommodation and furnishings, comfort allowances, liaison with other agencies, recreation, participation in and with the community, direct participation of residents and family members in the operation of facilities, and "normalization" and "de-institutionalization". The general quality of programs appeared to be more than adequate although there were still examples of low standards in individual facilities. These were well known by the program managers and efforts were being made to upgrade them or phase them out. There may also have been examples of overservicing as suggested by the wide range of costs in children's facilities and the very high input of resources into the mental hospitals, and to a lesser extent, into chronic care for adults.

1. Evaluation of Effectiveness

In the matter of psychotherapeutic technology for both children and adults the instruments of research were still very crude. What there was, together with the concrete day-to-day evidence of experience, suggests that the impact of treatment achieves only marginal improvement over the normal changes wrought by time and the use of drugs. Simply put, many people with serious personal problems do improve but it is

not clear why.

At a recent Health and Welfare conference in Calgary, Dr. Sol Garfield, Professor and Director of Clinical Psychology at Washington University in St. Louis, who has spent all of his long career in the evaluation of therapeutic effectiveness in the field of mental health, put forward this view in a most convincing manner. He also pointed out that most practising psychotherapists in the many disciplines, both trained and untrained, representing about sixty or seventy different philosophies from psychoanalysis to Zen Buddhism, had faith - or at least expressed faith - in being able to help people. He also said that very few practicing psychotherapists were concerned about, or interested in, researching effectiveness of therapy in order to justify that faith.

This is not to suggest that all psychotherapeutic treatment facilities should be closed. People still need places to go when society and/or their families can no longer cope with them. It does, however, call into question the very high cost levels accorded to such facilities and this should perhaps be made the subject of intensive study. Other high cost services for physical treatment procedures might also benefit from such study.

2. Size of Facilities

Another major weakness was the size of institutions where people who were already vulnerable tended to become dehumanized. It has been suggested that "institutionalization", i.e., the loss of self-reliance, self-confidence and initiative, takes place far more quickly than is generally supposed, so that reduction in length of stay alone may not be the answer. More and more, professionals believe that such experience

is destructive rather than helpful and the residents who live through it feel this even more strongly. The need is for meaningful participation in the essential activities of daily life which is typical of group homes, foster homes, and independent supervised living situations. No doubt institutions can and are being improved by creating such opportunities, but it is much more difficult in large settings. Having said this, there will obviously be a continuing need of total care for the helpless but such classifications need to be made with a great deal of caution. For example, persons residing in the Approved Home programs of the Psychiatric Hospitals and the Mental Retardation Facilities were regarded by some staff members as "psychologically dead". A brief was written by the Ontario Association for the Mentally Retarded protesting this stage of affairs and suggesting that many of them might benefit from reactivation programs.

SUPPLY

Although growth of residential programs has taken place slowly in recent years in institutional facilities for the older age group, (see Appendix E on page 65 of the main Report) it has been more rapid and with considerable innovation in group homes for children, youth and adults. There did not appear to be critical shortages in any areas except for the physically handicapped and the alcoholics. Shortages in some programs (see program analysis Appendix D on page 44 of the main Report) might have been more a matter of proper utilization and home care support services than of true supply.

1. Children's and Youth Facilities

In some programs like the Correctional facilities for children and the Children's Aid facilities where most placements occur as a result of court and police action, there were wide fluctuations in admissions and

the facilities had little say in the matter of control. In these two programs, for example, the proposed amendment of Section Eight in the Training Schools Act, and complete revision of the Federal Juvenile Delinquents Act, were expected to sharply increase the demand for beds and require substantial program changes. In the past few years, however, there has been a marked reduction in admissions to Training Schools and Children's Aid Societies.

Unequal funding, and therefore expansion, under the Children's Institutions Act, the Child Welfare Act and the Children's Mental Health Centres Act, had also caused conditions of over and under-supply.

2. Mental Hospitals and Retardation Facilities

There appeared to be an over-supply of beds in Mental Hospitals which was complicated by the ongoing shift in responsibility for the mentally ill to Active Treatment Hospitals. This shift was considered highly desirable since the length of treatment and subsequent social problems appeared to be very much affected by the patient's image of himself as "mentally sick". The stigma associated with Mental Hospitals had a negative effect on the patient's concept of himself.

Reductions in the number of beds in Mental Hospitals were ongoing, but offsetting this were the developments of community mental health care and home care support services, for which the freed space was largely being used.

There was a short supply of beds in the Mental Retardation Facilities but this shortage was being gradually relieved by the falling birth rate and more selective admissions. There were still large numbers of retarded

in these facilities, however, that might be more effectively served in lower-cost community based group home facilities, foster homes and supervised independent living. A program to achieve this including home care support services and protective services has been established but is proceeding slowly.

3. Correctional Facilities

Institutional growth has been slowed and even reversed with the closing of some training schools as a result of the courts and police using more "diversion", the term for non-residential options.

UTILIZATION

Classification of Needs and Services

In general the impression left by the program review was that information about the supply and quality of facilities was adequate but that there were great gaps in specific knowledge about utilization. Of the twenty-three programs only Correctional facilities, Schedule I and II Facilities for the Retarded and Extended Care, made any systematic attempt to classify clients and place them in facilities appropriate to that classification. Even these made only partial efforts to establish levels of service from the least intensive to the most intensive, and relate them to cost. The matter of classification lies at the heart of the systems approach outlined in our Basic Proposal. In simple terms we need to know specifically what an applicant needs, where that need can be met, how much it will cost and what the service options are. Two recent papers dealt specifically with this matter and both spoke directly to the inadequacies of the Ontario scene. One was by Mr. S. Dubas, a former management consultant and now Director of Project Planning and Development for the Department of Health

and Welfare in Ottawa and the other was Mrs. J. Perrier, Ph.D., Research Co-ordinator, Clearing House, Criminal Justice, Chicago. Mrs. Perrier had developed a general method of classification and Mr. Dubas had in practice a method of quantifying social service delivery systems tested on the Federal OAS-GIS program. Both of these methods conceded the fact that service effectiveness could not be measured to the ultimate degree but did suggest practical ways of systematically controlling resource input and some areas of output. Furthermore, the Ontario experience, particularly in Corrections, suggests that a comprehensive approach to classification and levels of service may make a major contribution toward rational delivery throughout all the programs.

In Extended Care the increasing distortions of the "12 point" application form, appeared to arise in large measure from the lack of effective classification of needs and services in the complex of facilities within which it operates. As greater pressures were brought to bear on physicians to reduce personal costs of residents in Homes for the Aged and Nursing Homes, it seemed likely that more patients would be qualified for Extended Care whose needs might have been served at a less intensive level of care.

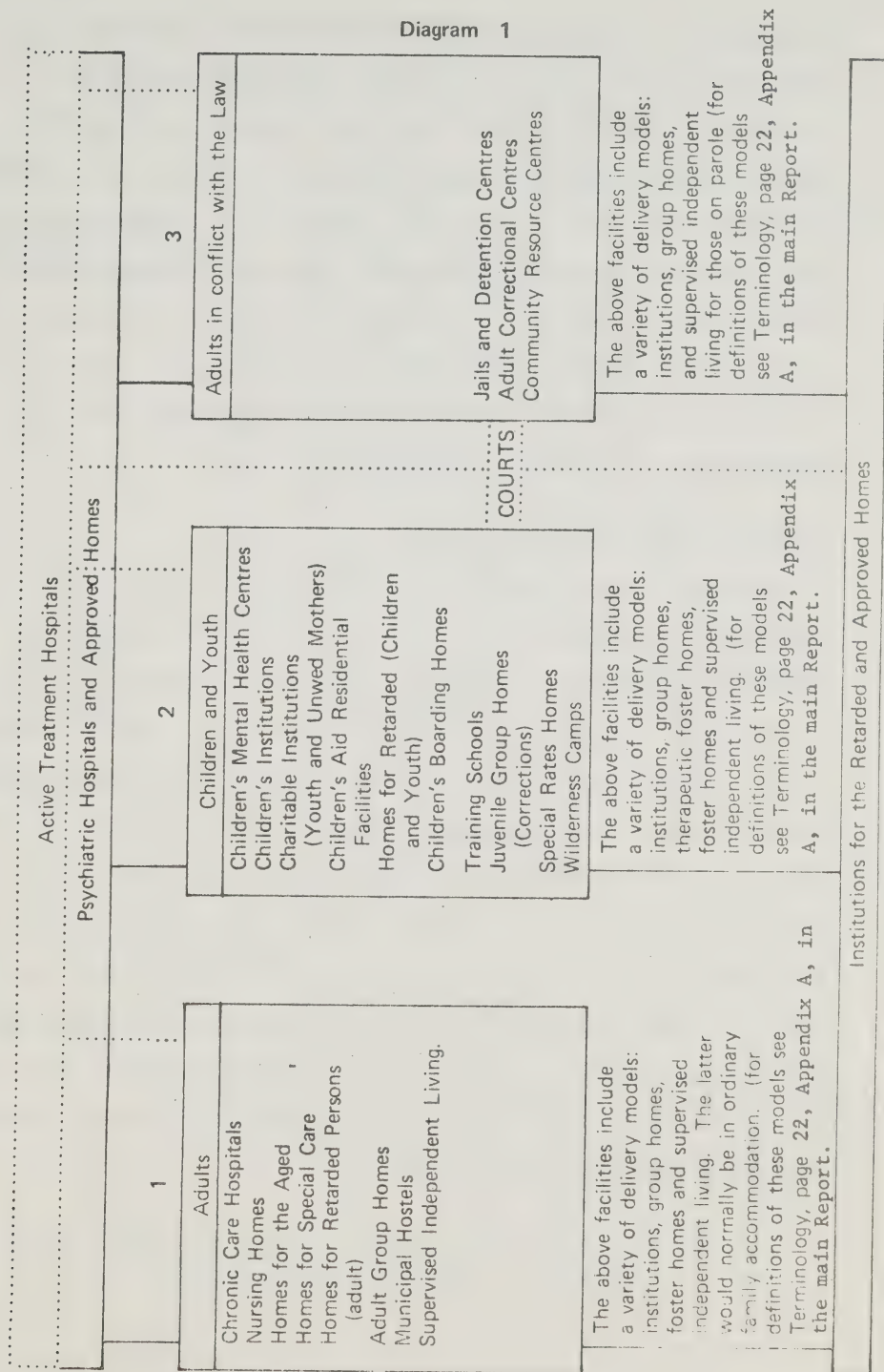
Hand in hand with classification the need was seen for admission control. Almost all of the facilities determined their own admissions policies and practices without co-ordination or direction, and this appeared to result in substantial waste and inappropriate use of resources.

SIMILARITY OF NEEDS AND SERVICES

Target Group 1 - Adults

In reference to the three Target Groups shown in Diagram 1, page 25, an obvious question is whether the needs of the clients and the service

INTERRELATED RESIDENTIAL SERVICES BY TARGET GROUPS (1, 2 AND 3)
"BROAD BANDED"



The above three target groups are the basis for the work groups in diagram 1 and the service committees in diagram 2.

modes and facilities had sufficient similarity to be organized as a continuum of care. This was affirmed for the great bulk of the facilities in the Adult Target Group, with Chronic Care Hospitals, Nursing Homes, Homes for the Aged, and Homes for Special Care, showing close relationship in both respects. While all of the Municipal Hostels, Adult Homes for Retarded and Group Homes were not quite so closely related, some of them were and the remainder were not so different as to be entirely excluded. An example of the continuum of care for senior citizens is shown on the next page and this could be applied with modifications to our three Target Groups.

Target Group 2 - Children and Youth

In comparison with the bewildering variety of standards, funding levels, procedures, and centres of authority, the children's needs and the facilities and services, presented a remarkable uniformity; so much so that it would be entirely consistent to treat them as part of one system, which is in fact done in some Provinces. Furthermore, children moved freely from one type of facility to another despite diagnostic considerations, strongly suggesting that service differences between the labelled categories were superficial. The common thread seen in most of the children's residential facilities was the provision of food, shelter and personal amenities, and, while the programs did have varying specialties, they were also very similar in such matters as staffing patterns, qualifications and experience of staff, recreation, socialization, community contact, transportation, administration, etc.

THE CONTINUUM OF CARE

A TARGET GROUP EXAMPLE FOR SENIOR CITIZENS

<p>Independence</p> <p>Self-Sufficiency Involvement Role Replacement</p>	<p>Nutrition and Health Promotion Services</p> <p>Employment</p> <p>Volunteer Services</p> <p>New Horizons Projects</p> <p>Information and Referral</p> <p>Transportation</p> <p>Continuing Education and Recreation</p> <p>Private Pension Plans</p> <p>Tax and Discount Concessions</p> <p>Social Activity and Drop-In</p> <p>Housing Registries</p> <p>Information Counselling - legal - protective</p> <p>Library Services</p> <p>Community Outreach</p>	<p>Health (Preventive)</p>
<p>Partial Dependence</p> <p>Mutual Support Community Support</p>	<p>Friendly Visiting</p> <p>Meals-on-Wheels</p> <p>Health Counselling</p> <p>Home Help</p> <p>Home Repair</p> <p>Health Aides</p> <p>Home Nursing</p> <p>Co-ordinated Home Care</p> <p>Therapeutic Counselling</p> <p>Residential Services</p> <p>Public Housing</p>	<p>Specific Problems</p>
<p>Dependence</p> <p>Complete Care</p>	<p>Special Care Homes</p> <p>Geriatric Day Hospitals</p> <p>Nursing Homes</p> <p>Convalescent Hospitals</p> <p>Active Treatment Hospitals</p> <p>Auxiliary Hospitals</p>	<p>Illness (Treatment)</p>

Prepared by Mr. D. R. Milne, Director of Social Planning,
Edmonton Social Services

Target Group 3 - Adults in Conflict with the Law

The need for a secure setting was the factor determining separation of this Group from the adults in Group 1. But even here Temporary Absence and Parole programs were being used more and more to reduce the differences. However, at the present stage of development this may be regarded as a homogeneous group of "clients", services and facilities.

MECHANISMS OF THE BASIC PROPOSAL

The large body of information gathered first by the Committee on Group Homes and then the Committee which produced this Report, was not considered adequate for specific recommendations at this time. The main reasons were the complexity of the information itself, the maze of interrelated problems and the need for classification of levels of care and corresponding resources related directly to costs, and co-ordination of admissions and discharges. The Committee therefore decided on mechanisms that would test these processes over time and through actual experience, and unravel the problems and complexities gradually.

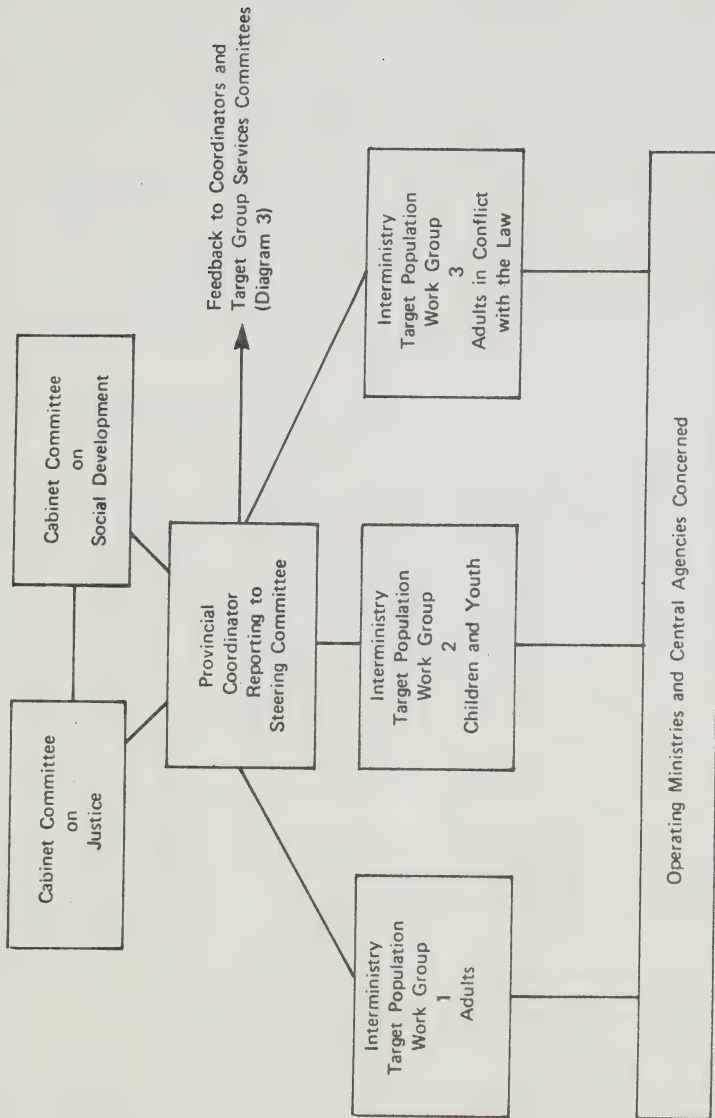
The mechanisms shown in Diagrams 2 and 3 on pages 29 & 30 outline the Basic Proposal of the Committee. The Proposal was made without alternatives because it is comprehensive in nature. Alternatives could only be piecemeal, and as we have already seen, whenever changes are made in individual programs without reference to related services and facilities, new problems are created to add to the existing ones.

Stage One - Guide Lines

In this scheme (Diagram 2) Target Population Work Groups would be set up for each of the three Target Groups, Adults, Children and Youth, and Adults

Diagram 2

MODEL FOR THE DEVELOPMENT OF INTERMINISTRY PROGRAM GUIDE LINES (time limited structure)

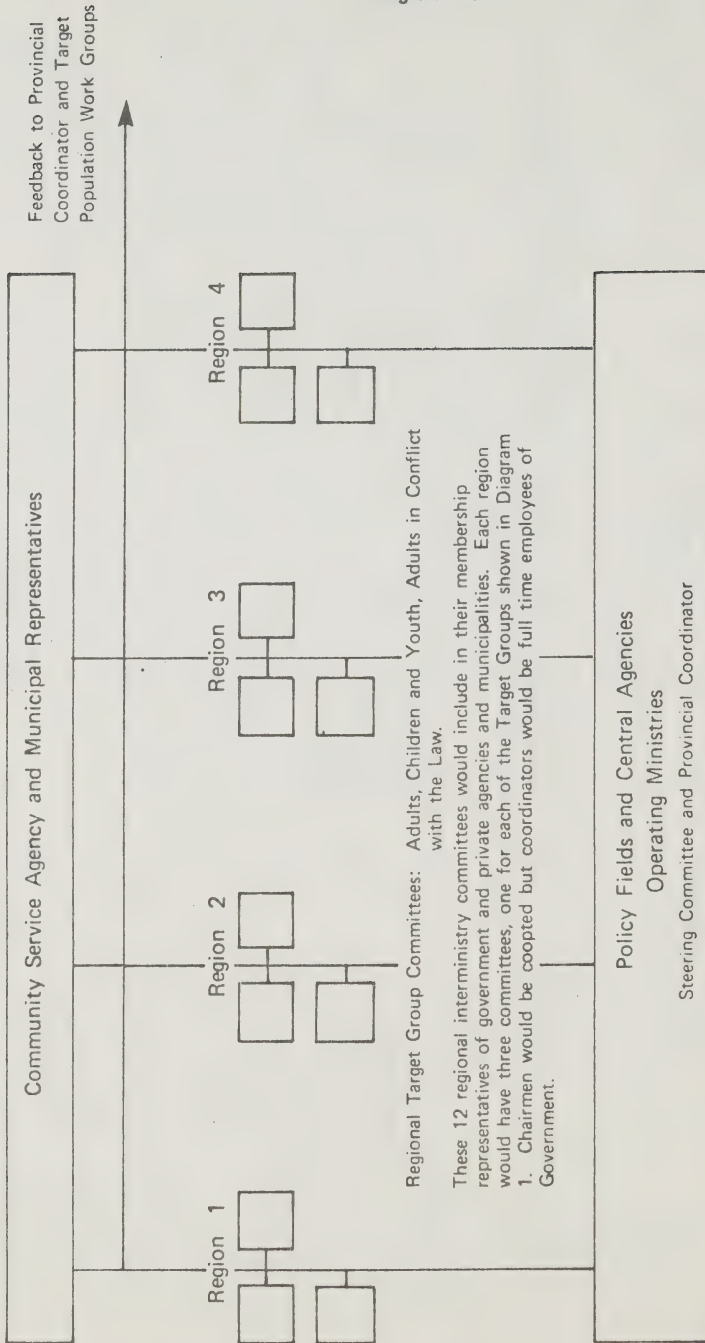


RESPONSIBILITIES OF INTERMINISTRY TARGET POPULATION WORK GROUPS:

1. Specification of target group.
2. Classification of persons in need of service.
3. Identification of services required and gaps (private and public agencies).
4. Policy concerning purchase of service.
5. Identifying antiquated facilities and service duplication.
6. Evaluation of services (cost/benefit).
7. Design of admissions and flow control system.
8. Non-residential alternatives.
9. Communications patterns.
10. Consideration of federal cost sharing.
11. Revision of guide lines on feedback from Target Group Services Committees.
12. Comment on interministry issues and problems.

Diagram 3

OPTIONAL MODEL FOR EVALUATION AND IMPLEMENTATION OF PROGRAM GUIDELINES (time limited structure)



RESPONSIBILITIES OF TARGET GROUP COMMITTEES

1. Communicating with all regional groups concerned.
2. Testing of guide lines from Work Groups.
3. Recommending legislative change and service auspices.
4. Inequities of financial recoveries from residents and discretionary income.
5. Coordination - admission flow and control.
6. Monitoring trends in demand for service.
7. Evaluation of services.
8. Monitoring gaps in service.
9. Community development of non-residential services.
10. Zoning and community acceptance of residential facilities.
11. Monitoring funding inequities.
12. Advising Government re need for programs requested by communities.

in Conflict with the Law, in order to prepare a broad set of guide lines. The work groups would be comprised of senior program and financial personnel from each of the twenty-three programs and would be allowed sufficient free time to meet on a regular basis. With regular meetings, and the support of their own program and financial staff, the Work Group members should be able to complete the guide lines within six months covering the topics shown at the bottom of Diagram 2 and additional ones they may identify. Their major task would be classification of needs and corresponding services and facilities, and setting cost-related levels of care for each of the three Target Groups.

Stage Two - Implementation

When the guide lines were completed to the satisfaction of the Steering Committee and the Cabinet, consideration should be given to their implementation. Diagram 3 on page 30 proposes an optional structure for this stage and outlines the responsibilities of the regional Target Group Committees. As far as possible the regions used would be made to conform with the existing regional structures of the participating Ministries with local sub-committees serving smaller geographic units.

There would thus be three Committees representing the three Target Groups in each of the four regions. It is proposed that the Committees have a full-time co-ordinator and a part-time chairman from the region, the latter being chosen as the most suitable for each Target Group and appointed by the participating Ministries. The regional co-ordinators would be appointed by the Provincial Co-ordinator who would be responsible to the Steering Committee for the staging and completion of the two projects. Appropriate outside agency and municipal

representatives would be included as committee members, as well as local representatives of the Ministries.

The first major task of the Committees would be to test the guide lines in practice and feed the information back to the Provincial Co-ordinator for further policy direction. Program staff employed in Stage One would still be involved in Stage Two on an ad hoc basis. The second major task would be to involve all the agencies concerned in setting up standard and complementary admission criteria to regulate the flow of clients through the Target Group system according to the specific levels of care in the guide lines. Out of this process should eventually come designated costs for each level of care. At the present time such costs are largely set by the facilities themselves.

This stage should take two years to complete, following which, the full-time co-ordinators could be reassigned to other duties and the regional Committees continue to report to the Provincial Co-ordinator or some other designated person with responsibility for the continuing work of admission flow and control.

APPENDIX L

PROJECT TWO

EQUAL FINANCIAL RECOVERIES FROM INDIVIDUALS IN

RESIDENTIAL CARE

Income Security Division
Ministry of Community &
Social Services
April, 1975.

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I SUMMARY

INTRODUCTION

Introduction of the GAINS (AGED) program had implications for many residential care clients. GAINS payments were intended to assist low income aged persons in the community to meet high living costs. If GAINS benefits had been passed on to persons whose needs were already being met through residential care programs at little or, in some cases, no charge, multiple subsidization would have occurred.

This problem was resolved in part by the introduction of increases in the Extended Care co-insurance rate. However, some multiple subsidization continued as GAINS benefits were paid to clients of other residential facilities.

This situation, in turn, raised questions concerning the possibility of introducing a universal recovery charge to all residential care clients. That is, a flat rate charge to cover the costs of "room and board" in these facilities.

OBJECTIVE

To examine the feasibility of equalizing financial recoveries from individuals in residential care.

CURRENT SITUATION

At present, there is no overall policy regarding charges to individuals in residential care facilities. A broad range of practices exist - from situations in which no direct charge is made against the client as all services are covered by health insurance, to situations in which facilities attempt to recover all of the costs from the client, or his family. For example, practices vary:

- by client groups (e.g., mentally retarded are treated differently than the aged);
- within client groups (e.g., the aged in a Home for the Aged are treated differently than those in a Home for Special Care);
- within the same facility (e.g., residential care clients in Homes for the Aged are treated differently than extended care clients in the same home);
- by different facilities which provide essentially the same level of care (e.g., supervised board and lodging for aged persons are provided by both Homes for Special Care - Residential Homes and Licenced Approved Homes under Psychiatric Hospitals - but the charges are different);

- without relationship to the degree of service provided by the facility (e.g., a chronic care hospital resident receiving a minimum of 76 hours of nursing care per month on average pays nothing for room, board or health care, while a residential care client in a Home for the Aged is billed an average \$360 per month);
- without relationship to ability to pay (e.g., a wealthy resident on extended care in a Home for the Aged pays about one half of the average amount billed a person in residential care in the same Home for the Aged);
- in relation to the source of income (e.g., Adult Group Homes for the Physically Disabled have based their charge on the level of income provided by the GAINS (DISABLED) program.
- according to Provincial legislative requirements (e.g., facilities under the Charitable Institutions Act must meet 20% of their operating costs with non-government funds and have to adjust their resident charges accordingly);
- according to Federal legislative requirements (Canada Assistance Plan) (e.g., in M.R. Schedule I facilities, residents are billed \$30 per day, in order to obtain cost sharing in those facilities);
- with the objectives of the program (e.g., M.R. community residences do not charge a resident all his GAINS (DISABLED) income so that the resident can learn how to use funds wisely;
- against the objectives of the program (e.g., the assets of M.R. Schedule I clients are assessed at the rate of \$30 per day to facilitate cost sharing which taxes the resources of an individual which he may require to be self-sufficient on his return to the community).

These variations appear to result in situations which are not only in conflict but are also inexplicable to the general public.

For example, comparisons can be made between situations in which:

- the charges for government services decrease as the amount of service increases;
- the "poorest" clients may appear to pay the highest charges.

CONSTRAINTS

It was considered that the introduction of a uniform room and board charge for all residential facilities might have a number of advantages. For example:

- re-inforcement of individual responsibility;
- increased equity;

- simplified administration;
- greater consistency and ease of public understanding.

However, the introduction of a universal room and board rate does not either address itself to, or reconcile the underlying factors which have produced the existing situation.

Variations in charging practices appear to be caused by three major factors.

1. Ministerial Orientation - Residential care is provided primarily by the Ministries of Health and Community and Social Services. The Ministries differ markedly in respect to:
 - (a) Policy Orientation - Health services are based on a universal service concept using a social insurance mechanism. In contrast, MCSS programs are based on a more selective service concept with an orientation toward a "welfare or needs tested" approach.
 - (b) Cost Sharing Provisions - Reflects the policy orientation of the respective ministries. That is, the "needs oriented" Canada Assistance Act versus the Hospital Insurance and Diagnostic Services Agreement and Medical Care Agreement.
2. Individual Program Objectives
3. Clients' Income Source and Ability to Pay

The introduction of a universal room and board charge across all residential care programs assumes that these fundamental differences in Ministerial orientation, program objective and clients' ability to pay are either:

1. sufficiently compatible to accept this adjustment, or
2. can be readily adjusted to facilitate the introduction of a universal charge for room and board without adverse implications.

Neither condition appears to exist at present.
Differences in orientation are profound; e.g.

- the introduction of a charge for room and board in certain health facilities would be more compatible with the MCSS approach, but would infer a fundamental policy change in respect to benefits provided through health insurance.
- Similarly, application of the extended care rate in M.R. facilities might jeopardize their cost sharing under CAP.

It would also appear to be inappropriate to introduce a universal charge when major changes in both income maintenance and cost sharing of social services may occur during the next two years.

CONCLUSION

1. A universal residential charge will not reconcile fundamental differences in orientation, objectives, etc. It will only alleviate some of the anomalies which result from these differences, and create many other problems.
2. However, the development of a broad "charging policy" which is sufficiently flexible to accommodate differences in orientation, program objectives, client characteristics appears to have considerable merit.
3. If such a policy were adopted, two alternative approaches appear to be possible:
 - (a) development of a "charging policy" as one component of a wider, overall re-assessment of residential care policies and practices; i.e., the "charging policy" must reflect the fundamental orientation and goals of residential care programs.
 - (b) acceptance of an incremental approach; i.e., a step by step rationalization of charging on a target group basis within existing constraints.

RECOMMENDATIONS

1. THAT A UNIVERSAL CHARGE FOR ROOM AND BOARD NOT BE SUPERIMPOSED ON THE EXISTING RESIDENTIAL CARE STRUCTURE.
2. THAT THE PRINCIPLE OF CHARGING FOR CERTAIN ASPECTS OF RESIDENTIAL SERVICES BE ADOPTED BUT APPLIED IN A FLEXIBLE MANNER TO ACCOMMODATE DIFFERENCES IN ORIENTATION, OBJECTIVES AND CLIENT CHARACTERISTICS.
3. THAT THIS PRINCIPLE BE REFLECTED IN FORTHCOMING NEGOTIATIONS IN RESPECT TO COST SHARING OF INCOME MAINTENANCE AND SOCIAL SERVICES.
4. THAT A FLEXIBLE CHARGING POLICY SHOULD BE DEVELOPED AS ONE COMPONENT OF A SYSTEMATIC REVIEW OF THE OBJECTIVES AND OPERATION OF THE PROVINCIAL RESIDENTIAL CARE SYSTEM.
5. THAT IF RECOMMENDATION FOUR IS NOT ACCEPTABLE, AN INCREMENTAL RATIONALIZATION OF EXISTING CHARGING PRACTICES SHOULD BE UNDERTAKEN, PREFERABLY ON A TARGET GROUP BASIS BEGINNING WITH THE AGED.

II BACKGROUND

The introduction of the GAINS-Aged program highlighted concerns over multiple subsidies of public funds being provided for the care of the same resident. When a residential care facility makes no financial recovery from the client (see (1) below) and when direct cash transfers are made to these same clients (see (2) below), then multiple subsidies (see (3)) arise.

(1) Financial Recoveries

Financial recoveries are currently NOT assessed by the following residential programs:

- chronic care hospitals and units
- psychiatric hospitals and licenced approved home
- active treatment hospitals.

(2) Direct Cash Transfer Payments

Policies with respect to payment of direct cash transfers to individuals on residential care programs varies from program to program.

Some programs pay maximum benefits to all institutionalized recipients:

- Old Age Security (OAS), because of its philosophical base, as a demogrant;
- Guaranteed Income Supplement (GIS) which is tied to OAS;
- Provincial Guaranteed Annual Income System payments to the aged (GAINS-Aged) which ties eligibility to GIS;
- Workmen's Compensation (WC), Canada Pension Plan (CPP) disability and retirement pension, etc., because of their social insurance nature.

Individuals on any residential care program are eligible for a provincial tax credit but the amount of benefit is lower to residents on programs which do not make financial recoveries. In practice, tax credits to the non-aged in such facilities are not applied for, as only the sales tax component would be payable. The following chart illustrates the case of an individual with no taxable income.

RECIPIENT	TOTAL TAX CREDIT	AGED COMPONENT	SALES TAX COMPONENT	PROPERTY TAX COMPONENT*
Aged, \$5.90 per diem	335.72	110	27.72	198.00
Non-aged, \$5.90 per diem	215.06	Nil	17.06	198.00
Aged, no per diem	137.72	110	27.72	Nil
Non-aged, no per diem	17.06	Nil	17.06	Nil

(3) Multiple Subsidies to Institutionalized Residents

The interplay between direct transfer payments and financial recoveries may make certain groups eligible for multiple subsidies of public funds. Appendix III is a preliminary analysis of the types of transfers going to clients of various residential care facilities. It shows that the aged, because they have a guaranteed minimum income, are receiving the bulk of the multiple subsidies.

Some others receiving multiple subsidies consist of social insurance beneficiaries of such programs as Canada Pension Plan disability benefits, Workmen's Compensation benefits, etc.

*Assumes rental component if per diem is \$2.47 or \$900 per year.

Everything else remaining the same, the number of individuals receiving such multiple subsidies would increase if:

- the Federal-Provincial Income Security Review places greater emphasis on social insurance as the first line of defence (e.g., higher benefits, broader eligibility definition, coverage of individuals disabled at birth, etc.).
- the concept of the philosophical right to a guaranteed income (e.g., Federal GIS program) is reflected in other direct transfer programs.

III EQUALIZED FINANCIAL RECOVERIES

The introduction of equalized financial recoveries was seen as a potential solution to the problem of multiple subsidies benefitting residential care clients. This section (1) briefly outlines the present recovery practices and (2) describes the concept of equalized financial recoveries.

1. Present Recovery Practices

Financial recoveries from individuals in residential care vary from program to program.

Financial recoveries, where possible (and appropriate), are now made under the following programs up to the maximum amounts indicated:

<u>Facility</u>	<u>\$ Per Diem</u>
Adult Group Home	5.25 average
Home for the Aged - Extended Care	5.90
Nursing Home - Extended Care	5.90
Home for Special Care - Extended Care	5.90
Home for Special Care - Residential Home	8.15
Municipal Hostels	8.30 average
Home for Aged - Residential Care	12.00 average
Nursing Home - Intermediate Care	15.75
Mental Retardation Schedule I Facility	30.00

Actual policies with respect to recoveries will vary from program to program. For example:

- Homes for Special Care (Residential) no longer assess costs to relatives living in the community; whereas such requests may be made to relatives in Homes for the Aged residential care program.
- For the majority of residents in mental retardation facilities, the financial recovery will take the form of a bookkeeping transfer from Family Benefits to the facility itself.

Financial recoveries are currently NOT assessed by the following residential programs:

- chronic care hospitals and units
- psychiatric hospitals and licenced approved homes
- active treatment hospitals (not included in terms of reference of Project Two).

2. Concept of Equalized Financial Recoveries

The concept of equalized financial recoveries is based on the principle that long term residents in adult residential facilities should:

- (i) all contribute to their maintenance where possible.
- (ii) but only be responsible for the cost of the food and accommodation components of their care.

Two ways to measure the costs of the food and accommodation components were attempted.

(a) Project Three

The first way was to attempt to collect standardized data from each type of facility so that the food and accommodation costs could be separated out. (See description of Project Three) Once collected, these data could be used to either total the food and accommodation costs or, alternatively, to deduct the health related component of care (i.e. 'food and accommodation' could be defined to include all non-health services).

There are two major reservations to this method of calculation:

- (i) Rates charged could vary from program to program depending on the institution's size and efficiency. Thus residents could face varying levels of charges depending on the facility in which they reside - which often happens to be the residence which had a vacancy when they required one.
- (ii) Government accounting practices make the calculation of the accommodation component inaccurate. Should the cost of the facility be amortized? What interest charges should be imputed? Should any adjustment be made for the current market value?, etc.

(b) Cost of food and accommodation in the community

The other method to calculate the food and accommodation component involved examining the cost of comparable services in the community.

For discussion, an estimate of current private sector charges was determined. The range* so chosen varied somewhere between \$150 and \$215 per month. The present \$5.90 extended care co-insurance rate is within this range (it averages \$179 per month).

*Based on a telephone survey of 60 board and lodging vacancies across the province in February/March, 1975.

ACCORDINGLY IN THE REMAINDER OF THE PAPER THE CONCEPT OF EQUALIZED FINANCIAL RECOVERIES REFERS TO A COMMON CHARGE THAT WOULD APPLY EQUALLY IN ALL FACILITIES BASED ON CHARGES FOR BOARD AND LODGING IN THE COMMUNITY.

IV QUESTIONS CONCERNING THE TRANSFER SYSTEM SERVING RESIDENTIAL CARE CLIENTS

The present system faces each client group with a spectrum of programs that is characterized by inconsistencies, inequities and anomalies. The following four sections question the effect of the present transfer system serving individuals in different residential care client groups. Appendix IV highlights the varying program design characteristics of selected cash transfer programs.

The four largest client groups have been selected: (i) the aged, (ii) medical problems, (iii) mentally ill, and (iv) mentally retarded. Similar analysis could also be done for the physically disabled, alcoholics and ex-offenders. However, the four groups selected account for by far the largest portion of the population in residential care. Appendix I compares the relative sizes of the different client groups receiving residential care.

QUESTIONS: 1. THE AGED

- What is the rationale for large variations in the discretionary incomes of the aged?

- Why does it increase as health deteriorates?

Municipal Hostel	\$ 50 discretionary (in practice usually \$43)
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Homes for the Aged:

- Residential Care	43 flat rate
- Extended Care	51 residual income

Chronic Care, Psychiatric and Active Treatment Hospitals	230
--	-----

- Why does discretionary income increase the further one moves from self-sufficient community living? For an aged person in the community to have \$51 of discretionary income (the level of a person in extended care in a home for the aged) he would have to feed, clothe, and shelter himself for \$179 a month.
- Why does the discretionary income of some residents rise and fall frequently? The discretionary income of aged Extended Care residents is the difference between GAINS and the Extended Care charge. Since GAINS escalates quarterly and the Extended Care rate changes less frequently, the discretionary income of the Extended Care cases is subject to wide fluctuations (see Table I overleaf). (In comparison, the comfort allowance of \$43 - e.g. to residential care cases in homes for the aged - is subject to infrequent periodic adjustment.)
- Why are some items provided free in some Homes for the Aged and charged for in others? e.g. Some homes provide reading materials, toiletries, clothing, etc., free of charge - others do not.
- Should current discretionary incomes in Homes for the Aged and Nursing Homes be reduced?

<u>Home for the Aged Program</u>	<u>Monthly Discretionary Income before Tax Credits</u>	<u>Monthly Discretionary Income after Tax Credits</u>
Residential care (14,000 are 65 or over)	\$43	\$71
Extended Care	51	79

TABLE I

COMPARISON: EXTENDED CARE AND RESIDENTIAL CARE

MONTHLY DISCRETIONARY INCOMES¹ THROUGH TIME IN HOMES FOR THE AGED

Month and Year	Extended Care	Residential Care	Difference
December 1971	No Extended	\$25.00	N/A
January 1972	Care	33.50	N/A
February	Program	33.50	N/A
March	Available	33.50	N/A
April	\$51.30	33.50	\$17.80
May	51.30	33.50	17.80
June	51.30	33.50	17.80
July	51.30	33.50	17.80
August	51.30	33.50	17.80
September	51.30	33.50	17.80
October	51.30	33.50	17.80
November	51.30	33.50	17.80
December	51.30	33.50	17.80
January 1973	62.05	44.25	17.80
February	62.05	44.25	17.80
March	62.05	44.25	17.80
April	82.99	44.25	38.74
May	67.79	44.25	23.54
June	67.79	54.25	13.54
July	67.79	54.25	13.54
August	67.79	54.25	13.54
September	67.79	54.25	13.54
October	67.79	54.25	13.54
November	76.81	54.25	22.56
December	76.81	54.25	22.56
January 1974	75.17	62.98	12.19
February	75.17	62.98	12.19
March	75.17	62.98	12.19
April	78.49	62.98	12.19
May	78.49	62.98	12.19
June	78.49	62.98	12.19
July	78.97	70.98	7.99
August	78.97	70.98	7.99
September	78.97	70.98	7.99
October	87.30	70.98	16.32
November	87.30	70.98	16.32
December	87.30	70.98	16.32
January 1975	92.80	70.98	21.82
February	92.80	70.98	21.82
March	92.80	70.98	21.82

¹Discretionary Income for Extended Care Residents is calculated as follows:

OAS/GIS/GAINS

Plus

Ontario Tax Credits

Less

Co-insurance per diem.

Discretionary Income for Residential Care is calculated as follows:
Legislated Comfort Allowance PLUS Ontario Tax Credits

Ontario tax credits are added on as if received on a current monthly basis. Rental payments assumed to be:

1972	-	\$600 per year
1973	-	\$750 per year
1974/75	-	\$900 per year
1975	-	Tax credit regulations assumed to be same as 1974.

N.B. These rental payments yield the base occupancy cost for each taxation year (e.g. \$180 - 1975)

- Should there be varying philosophies amongst residential care facilities as to whether or not aged clients should make available all their resources to pay for their cost of care? For example, Charitable and Municipal Homes for the Aged and M.R. Schedule I facilities may charge assets and/or estates, while Nursing Homes, Chronic Care and Active Care Hospitals do not.
- Should there be varying philosophies within residential care facilities as to whether or not aged clients should make available all their resources to pay for their cost of care? For example, a residential care client in a Home for the Aged may be subject to strict asset and income testing (including the forced sale of a home) to pay for the cost of his care, while an Extended Care client in the same Home is not.

Does the above variation in practices affect the demand for residential care beds as opposed to extended care beds?

Why are there three basically different charging policies for the aged? Some facilities:

- (a) do not charge their aged residents even though they all have GAINS (e.g. chronic care, active treatment, or psychiatric hospitals);
- (b) charge their aged residents an amount small enough to be paid out of their GAINS (e.g. Extended Care residents in Homes for the Aged and Nursing Homes);
- (c) charge their aged residents an amount far too large to be paid out of their GAINS (e.g. Residential care residents in Homes for the Aged).

Does the fact that an Extended Care client in a Home for the Aged pays only \$179 per month on average for his care, and a residential care client in a Home for the Aged is billed on average about \$350 per month, create an incentive for the individual to obtain a higher level of care, or for the individual's family to obtain Extended Care on his behalf in the first instance?

- Why should a bed-ridden resident, totally incontinent of bowel who requires a catheter, qualify for Extended Care Insured Service, while a chair-ridden resident also totally incontinent of bowel and who requires a catheter, not qualify?
- Should the same co-insurance rate be charged in all facilities when Homes for the Aged offer varying program content and when the task force on long term care noted some Nursing Homes'

" a) failure to provide remotivation programs;

b) failure to provide a stimulating social environment;

- c) failure to involve community interest in the homes;
- d) failure to stimulate physician involvement in home standards.?"

- Within the same facilities, should an aged resident have a larger discretionary income than a non-aged resident?

<u>Facility</u>	<u>Aged</u>	<u>Non-Aged</u>
Homes for Special Care	\$230.50*	Nil
Home for Special Care - Residential Home	230.50*	Nil
Psychiatric Hospital	230.50*	Nil
Chronic Care Hospital	230.50	\$43

*Usually income is in the care of a public trustee who decides how much should go to the individual and how much to the facility.

- Should the domiciliary hostel program be reviewed? It is now providing residential care for some 900 aged, yet:
 - There are no minimum central standards of care;
 - Rates are determined in isolation from other similar facilities (e.g., Residential Home for Special Care).

QUESTIONS: 2. MEDICAL PROBLEMS

- Should the charge to a resident increase as level of care decreases?

Active Treatment/Chronic Care \$ Nil

Extended Care \$5.90

Visting Nurse (aver. per visit) \$9.50

- What is rationale behind the variations in amounts of discretionary income:

- from facility to facility;

- from aged to non-aged?

Facility	Aged	Non-Aged
Active Treatment	\$230	(usually \$43 minimum)
Chronic Care	230	\$43
Extended Care	51	\$43 maximum

- Why do the assistance programs for the non-aged impose asset restrictions which may hamper a return to the community (e.g. Family Benefits asset limit is \$1500)?
- Should there not be definitive policy guidelines governing the use of municipal discretionary authority in determining the level of comfort allowances to nursing home cases? Some municipalities arbitrarily impose limits below the maximum \$43.
- Is there a strong incentive for privately operated Nursing Homes to serve those residents whose care requirements are least expensive?

QUESTIONS: 3. MENTALLY ILL

- What is the rationale for the following pattern of discretionary income:

	<u>Aged</u>	<u>Non-Aged</u>
Municipal Hostel	\$ 43	\$43 (Discretionary)
Home for Special Care - Extended Care	230*	N11
Home for Special Care - Residential Home	230*	15
Psychiatric Hospital	230*	N11
Licensed Approved Home under Psychiatric Hospital	230*	15

*Usually income is in the care of a public trustee who decides how much should go to the individual and how much to the facility.

- Should only the aged be receiving any substantial amount of discretionary income?
- Why do the non-aged in psychiatric hospitals and Homes for Special Care - Residential Homes, receive no discretionary income even though the handling of money and the implicit choice it permits may prove useful preparation for return to the community?
- Why does a person in a licensed approved home under a psychiatric hospital, who is supposed to be leading as normal a community life as possible, receive only \$15 per month?
- Why does the daily charge to the resident decrease as level of care increases?

Municipal Hostel	\$8.30 (aver.)
Home for Special Care:	
- Residential	8.15
- Extended Care	5.90
Psychiatric Hospital	N11

- Why may rates be substantially higher (up to \$14.50 - average \$8.30) than rates under Homes for Special Care - Residential Homes (\$8.15)? Should municipal hostels be serving this group? If so, is there greater need for control or supervision?

- Should residents in psychiatric hospitals be eligible for income transfer payments? Federal cost sharing in these facilities might be increased (as it was for M.R. facilities) by making residents eligible for Family Benefits. The nature of these facilities has changed through time. For example, in 1955 only 11% of admissions were voluntary, while by 1972 this had increased to 56%.

QUESTIONS: 4. MENTALLY RETARDED

- Should not all residential situations provide a discretionary income if the common goal is to attain "normalcy"?

Monthly discretionary income varies as follows:

\$0	M.R. Facility
\$15 Max.	M.R. Licenced Approved Home
\$50 Max.	Municipal Hostel
\$0	Home for Special Care - Extended Care
\$0	Home for Special Care - Residential Care
\$43	Community Residence

- Is there an essential difference in service which justifies the following daily recoveries from any resources the resident might have?

Nil	Psychiatric Hospitals
\$5.90	Homes for Special Care - Extended Care
\$8.30 aver.	Municipal Hostel
\$8.15	Homes for Special Care - Residential Care
\$15.62	Community Residence
\$30.00	M.R. Schedule I and II Facility

- Why do two Acts (Homes for Retarded Persons, Developmental Services Act) operating under the same Ministry, have differeing policies regarding:

1. Charges
2. Comfort allowances
3. Transfer income
4. Funding.

- Why do those whose level of functioning is higher often have less money, fewer services and higher expenses when discharged to the community? Example: discharged resident who rents or boards and was not judged eligible for GAINS-D.
- Why is there no "separation" allowance for those who succeed in leaving the residential care stream and who usually have no resources with which to establish themselves in the community?

- Why is there no uniform practice in assisting individuals unable to meet resident charges?

Example:

- Homes for Special Care
 - M.R. Schedule I and II
 - Community Residence
 - Municipal Hostel
 - Family Benefits Act
 - Family Benefits Act
 - Charitable Institutions Act
 - General Welfare Assistance Act
- Why are there not consistent policies concerning treatment of earnings from a workshop?
 - Schedule I facilities and Psychiatric Hospitals - resident keeps full entitlement.
 - M.R. licenced homes offset first \$15 earnings against "comfort allowance".
 - Community residences tax earnings above \$50 per month at 75%.
 - Why is there not consistent practice with respect to recoveries from a spouse or relative?

Why are dependent children asked to contribute to parents in Homes for the Aged but parents are not charged for the care of their retarded offspring?

V ADVANTAGES AND DISADVANTAGES OF EQUALIZED FINANCIAL RECOVERIESADVANTAGES

1. Recognizes the individual's responsibility to contribute to his own maintenance where possible, and recognizes society's responsibility to meet extraordinary needs such as health or age-related items.
2. Increases the equity of many residential care situations. For example, it:
 - (a) reduces charges to certain clients who are financially burdened, e.g., many residential care clients in Homes for the Aged. At the same time it assesses charges to those who, under the present system, have an income but are not being charged, e.g., chronic care clients.
 - (b) rationalizes the discretionary incomes of residents in different types of facilities. For example, an aged person on GAINS would have the same residual income in whatever type of facility he resided.
3. Reduces financial incentive to either:
 - (a) leave the community and enter into a Nursing Home as an Extended Care client, or
 - (b) seek reclassification from residential care in a Home for the Aged to Extended Care in a Home for the Aged.
4. Simplifies administration, rate revisions, etc.
5. Can be explained easily to the general public.
6. Partially meets growing need to reduce multiple subsidies. In the absence of action now, the problem of multiple subsidies could become even more significant. There appears to be a trend in income security programs to place greater emphasis on social insurance mechanisms and on programs incorporating the philosophical right of receiving direct cash payments, regardless of residence.

DISADVANTAGES

1. Introduction of an equal charge does not either address itself to, or reconcile the underlying factors which have produced the situations shown to exist in Section IV. Some of the major underlying factors are discussed below.
 - (a) Ministerial Orientation - Residential care is provided primarily by the Ministries of Health and Community and Social Services. The Ministries differ markedly in respect to:
 - (i) Policy Orientation - Health services are based on a universal service concept using a social insurance mechanism, under which the care provided by psychiatric, chronic care, and active treatment hospitals is an insured health service and, as such, the resident's charge has been included in the previous payment of insurance premiums. In contrast, MCSS programs are based on a more selective service concept with an orientation toward a "welfare or needs tested" approach.
 - (ii) Cost Sharing Provisions - Reflects the policy orientation of the respective ministries. That is, the "needs oriented" Canada Assistance Act versus the Hospital Insurance and Diagnostic Services Agreement and Medical Care Agreement.
 - (b) Individual Program Objectives - Many residential care programs have the objective of helping people to eventually leave the residential care stream. Other programs are designed to maintain their clients for the rest of their days.
 - (c) Clients' Income Sources and Abilities to Pay - Some client groups, notably those over 65, all have a minimum income. Other clients have a wide range of income sources and levels depending on a host of criteria highlighted in Appendix V.

The introduction of a universal room and board charge across all residential care programs assumes that these fundamental differences in Ministerial orientation, program objective and clients' ability to pay are either:

- (a) sufficiently compatible to accept this adjustment, or
- (b) can be readily adjusted to facilitate the introduction of a universal charge for room and board without adverse implications.

Neither condition appears to exist at present.
Differences in orientation are profound: e.g.

- the introduction of a charge for room and board in certain health facilities would be more compatible with the MCSS approach, but would infer a fundamental policy change in respect to benefits provided through health insurance.
 - Similarly, application of the Extended Care rate in M.R. facilities might jeopardize their cost sharing under CAP.
2. It does not appear appropriate to introduce a universal charge at this time. Major changes in both income maintenance and cost sharing of social services may occur during the next two years. These changes may facilitate some means of rationalizing resident charges other than with a uniform rate. For example, the importance of the review of the Canada Assistance Plan to residential care practices is substantial. For example, under present CAP rules it is possible that a reduction in the rate technically charged residents in Mental Retardation Schedule I Facilities from \$30 to (for example) \$5.90, could result in a loss of Federal cost sharing of some \$4,400 per year on each resident.
3. The problem of multiple subsidization would continue. There are six basic ways of subsidizing a residential care client and the introduction of a uniform charge would appear to be only a re-allocation of these same six subsidies. Specifically, a uniform charge addresses only the first two of the six as shown below.
- (a) Cash Transfer Payments (It should be noted that their eligibility criteria and benefit structure often bear no relation to the objectives of the residential care program.)
 - (b) Situations in which there is no recovery from the resident.
 - (c) Financial recovery less than actual cost of care.
 - (d) Funds provided to resident to meet recovery assessed in (c).
 - (e) Funds provided to resident for him to keep as a comfort allowance.
 - (f) Supplementary cost transfer payments which are dependent upon entry into a residential program.

A uniform charge addresses itself only to subsidies (a) and (b), i.e., a person receiving a cash transfer payment would always be charged something. However, the uniform charge appears to require more subsidies of types (c) to (f). For example, type (c) subsidies would increase in the facilities listed below, as their charges to residents would be decreased by a uniform charge which

equalled the community board and lodge rate.

Mental Retardation Facility I	\$30.00
Nursing Home Intermediate Care	15.75
Home for Aged - Residential Care	12.00 average
Municipal Hostels	8.30 average
Home for Special Care - Residential Home	8.15

Also, type (d) transfers would be increased, under a standard-charge system, since it would be necessary to first provide some funds to all individuals before recoveries could be made.

4. Reduced equity for some residents with financial commitments in the community. A resident may have relatives partially or wholly dependent on him. He may also have to maintain a home or apartment in the community if his stay is not expected to be an extremely long one, e.g., chronic care, which may only be required for several months. Recoveries from such individuals may actually impede a return to the community.
5. May cause negative public reaction. The public has become accustomed to the provision of certain types of care without any financial recovery from the resident.
6. May be encouraging over utilization of some types of care. For example, the introduction of Extended Care made care of an elderly relative in a nursing home financially attractive for many. An even greater demand might be anticipated for such services as residential care in a Home for the Aged with the introduction of a recovery rate which is lower than the current charge.

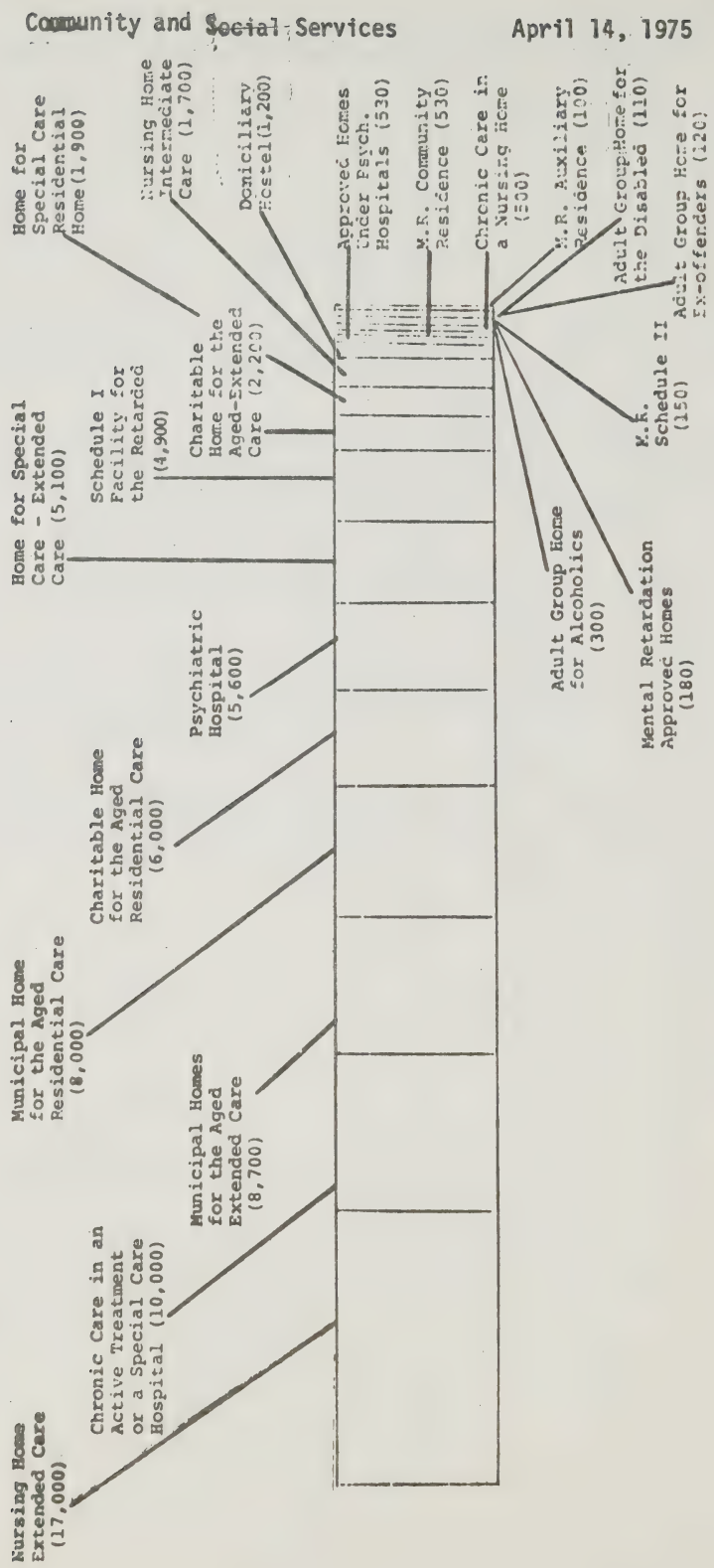
VI RECOMMENDATIONS

1. THAT A UNIVERSAL CHARGE FOR ROOM AND BOARD NOT BE SUPERIMPOSED ON THE EXISTING RESIDENTIAL CARE STRUCTURE.
2. THAT THE PRINCIPLE OF CHARGING FOR CERTAIN ASPECTS OF RESIDENTIAL SERVICES BE ADOPTED BUT APPLIED IN A FLEXIBLE MANNER TO ACCOMMODATE DIFFERENCES IN ORIENTATION, OBJECTIVES AND CLIENT CHARACTERISTICS.
3. THAT THIS PRINCIPLE BE REFLECTED IN FORTHCOMING NEGOTIATIONS IN RESPECT TO COST SHARING OF INCOME MAINTENANCE AND SOCIAL SERVICES.
4. THAT A FLEXIBLE CHARGING POLICY SHOULD BE DEVELOPED AS ONE COMPONENT OF A SYSTEMATIC REVIEW OF THE OBJECTIVES AND OPERATION OF THE PROVINCIAL RESIDENTIAL CARE SYSTEM.
5. THAT IF RECOMMENDATION FOUR IS NOT ACCEPTABLE, AN INCREMENTAL RATIONALIZATION OF EXISTING CHARGING PRACTICES SHOULD BE UNDERTAKEN, PREFERABLY ON A TARGET GROUP BASIS BEGINNING WITH THE AGED.

APPENDIX II:

COMPARISON OF
RELATIVE SIZES OF RESIDENTIAL CARE PROGRAMS

(NOTE: FIGURES ROUNDED)



APPENDIX III: PRELIMINARY ANALYSIS OF TYPES OF TRANSFER FOR MAJOR RESIDENTIAL CARE PROGRAMS SERVING:

2. THOSE WITH MEDICAL PROBLEMS (UNDER AGE 65)¹

TYPE OF PROGRAM	CARE TO CLIENT	TRANSFER PROGRAM 2	TYPE OF TRANSFER - FINANCIAL BASIS					NO PROTECTOR NEED
			DIRECT CASH REIMBURSE- MENT LOSS OF RESIDENT	DIRECT CASH REIMBURSE- MENT LOSS OF ASSIST- ANT	PER DIEM CARE LESS TRANS- FER	PROTECTOR COST FOR NURSING		
MINORITY HOME FOR THE AGED EXTENDED CARE	\$5.90 per diem extended care co-insurance premium (\$179 per month)	FAMILY BENEFITS			\$179	\$43		
		GRAND-DISABLE	\$230		\$179	\$43 discretionary		
		GENERAL ASSISTANCE						
		EXTENDED CARE PLAN			\$230			
		MANICULATION			PER DIEM			
GERIATRIC HOME FOR THE AGED EXTENDED CARE	\$5.90 per diem extended care co-insurance premium (\$179 per month)	FAMILY BENEFITS			\$179	\$43		
		GRAND-DISABLE	\$230		\$179	\$43 discretionary		
		GENERAL ASSISTANCE						
		EXTENDED CARE PLAN			\$230			
		MANICULATION			\$230			
NURSING HOME EXTENDED CARE	\$5.90 per diem extended care co-insurance premium (\$179 per month)	FAMILY BENEFITS			\$179			
		GRAND-DISABLE	\$230		\$179			
		GENERAL ASSISTANCE						
		EXTENDED CARE PLAN			\$230			
		MANICULATION			\$230			
GERIATRIC CARE HOSPITAL	NONE	FAMILY BENEFITS			\$179	\$43		
		GRAND-DISABLE	\$230		\$179	\$43		
		GENERAL ASSISTANCE						
		EXTENDED CARE PLAN			\$230			
		MANICULATION			\$230			
ACTIVE TREATMENT HOSPITAL	NONE	FAMILY BENEFITS			\$179	\$43		
		GRAND-DISABLE	\$230		\$179	\$43		
		GENERAL ASSISTANCE						
		EXTENDED CARE PLAN			\$230			
		MANICULATION			\$230			

¹ For the aged with medical problems - see Appendix III-1.² For transfer program payment criteria - see Appendix IV.

APPENDIX III: PRELIMINARY ANALYSIS OF TYPES OF TRANSFERS FOR MAJOR RESIDENTIAL CARE PROGRAMS SERVING:

3. THE MENTALLY ILL (UNDER AGE 65)¹

TYPE OF PROGRAM	COST TO CURE	TRANSFER PROGRAM?	TYPE OF TRANSFER (PLANNED BASIS)					NO TRANSFER
			DIRECT CASH REVENUE LESS OF RESIDENT	DIRECT CASH REVENUE ON RESIDENT	ASSISTANCE WITH PER DIEM COST OF CARE	PER DIEM CHARGED IS LESS THAN COST OF CARE	PROVISION OF OUTPATIENT TREATMENT	
DOMICILIARY HOME	Per diem of home is charged - Aver. \$6.30 (\$252/mo.)	FAMILY BENEFITS GAINS-DISABLED		\$170				
	Per diem of home is charged - Aver. \$6.30 (\$252/mo.)	GENERAL ASSISTANCE		230	\$52 aver			
	Per diem of home is charged - Aver. \$6.30 (\$252/mo.)	TAX CREDITS		18	\$252 aver		\$43 discretionary	
PSYCHIATRIC HOSPITAL	NONE	MINISTRY OF HEALTH TAX CREDITS		\$ 2				\$1650 aver
	NONE							
HOME FOR SPECIAL CARE - RESIDENTIAL HOME	Per diem of home is charged \$2.15/day (\$745/month)	FAMILY BENEFITS TAX CREDITS		\$16	\$248			
	NONE							
HOME FOR SPECIAL CARE - EXTENDED CARE	\$5.90 per diem extended care co-insurance premium (\$179 per month)	FAMILY BENEFITS EXTENDED CARE PLAN TAX CREDITS			\$179	\$363		
	NONE			\$18				
LICENSED APPROVED HOMES UNDER PSYCHIATRIC HOSPITALS	NONE	MINISTRY OF HEALTH TAX CREDITS		\$ 2			\$15	\$228
	NONE							

¹For the mentally ill aged, see Appendix III - 1

²For transfer program payment criteria, see Appendix IV

APPENDIX III: PRELIMINARY ANALYSIS OF TYPES OF TRANSFERS FOR MAJOR RESIDENTIAL CARE PROGRAMS SERVING:

4. THE MENTALLY RETARDED (UNDER AGE 65)¹

TYPE OF PROGRAM	COST TO CITY	TYPE OF TRANSFER					PROVISION OF CO-OP. PROGRAM	NO. OF TRANSFEREE
		DIRECT CASH REVENUE	DIRECT CASH DEFENDENT RESIDENCE	ASSISTANCE FOR DIET	PER DIEM CHARGED	PER DIEM CHARGED IS LESS THAN COST OF CARE		
COMMUNITY RESIDENCE	Per diem of home is charged. Aver. \$6.30 (\$475 per month). Range \$7 to \$14.50	FAMILY BENEFITS GRAND-CHILDREN GENERAL ASSISTANCE TAX CREDITS	\$170 230 18	\$248 aver.	\$43 discretionary			
HOME FOR SPECIAL CARE - RESIDENTIAL	Per diem of home is charged. Aver. \$15.62 (\$475 per month). Range \$7 to \$14.50	FAMILY BENEFITS GRAND-CHILDREN GENERAL ASSISTANCE TAX CREDITS	\$170 230 18	\$248 aver.	\$43 discretionary			
HOME FOR SPECIAL CARE - RESIDENTIAL	Per diem of home is charged. Aver. \$15.62 (\$475 per month). Range \$7 to \$14.50	FAMILY BENEFITS GRAND-CHILDREN GENERAL ASSISTANCE TAX CREDITS	\$170 230 18	\$248 aver.	\$43 discretionary			
PSYCHIATRIC HOSPITAL	Per diem of home is charged. Aver. \$15.62 (\$475 per month). Range \$7 to \$14.50	FAMILY BENEFITS GRAND-CHILDREN GENERAL ASSISTANCE TAX CREDITS	\$170 230 18	\$248 aver.	\$43 discretionary			
MENTAL HOSPITAL - FOR SPECIAL CARE	Per diem of home is charged. Aver. \$15.62 (\$475 per month). Range \$7 to \$14.50	FAMILY BENEFITS GRAND-CHILDREN GENERAL ASSISTANCE TAX CREDITS	\$170 230 18	\$248 aver.	\$43 discretionary			
MENTAL HOSPITAL - FOR SPECIAL CARE	Per diem of home is charged. Aver. \$15.62 (\$475 per month). Range \$7 to \$14.50	FAMILY BENEFITS GRAND-CHILDREN GENERAL ASSISTANCE TAX CREDITS	\$170 230 18	\$248 aver.	\$43 discretionary			

1 For the mentally retarded, aged, see Appendix III-1

2 For transfer program payment criteria, see Appendix IV

APPENDIX IV: PROGRAM DESIGN CHARACTERISTICS OF SELECTED CASH TRANSFER PROGRAMS

PROGRAM	UNIT DEFINITION	ASSET TESTING	ACCOUNTING PERIOD	INCOME TREATMENT	AMOUNT OF TRANSFER (Single rate)	COMMENT
OAS	Individual	None	N/A	N/A	\$123.42	Demogrant
GIS	Spouse Incl'd.	None	Annual	50% reduction rate on "taxable" income	Up to \$86.57 per month	Increment to OAS
GAINS-A	Spouse Incl'd.	None	Annual	100% reduction rate on OAS/GIS and taxable income	Up to \$230.50 per month	Increment to OAS/GIS
GAINS-D	Family	\$1500 indiv. + 1000 spouse + 300 each add'l. dependent	Monthly	100% reduction rate on transfer income. 75% reduction rate on all earned income above \$50/mo. single and \$100/mo. married	Up to \$230 per month	Varies with age and number of dependent children
F.B.A.	Family	As for GAINS-D	Monthly	As for GAINS-D above	\$170/mo. or if aged, \$200/month	Varies with actual shelter costs, age and number of dependent children
G.A.	Family	Discretionary at Municipal level-usually one month's entitlement	Monthly	100% reduction rate on transfer income. No less than 75% reduction rate on earned income above no more than \$50/mo. single and \$100/mo. married (at Municipal discretion)	\$163/mo. or if aged, \$193/mo.	Varies with actual shelter costs, age and number of dependent children
W.C.: (1) Worker (2) Widow	N/A Family	None None	N/A N/A	N/A N/A	\$250 - \$625/mo. \$250/mo.	Varies with previous earnings and degree of disability Flat rate plus marginal rate for dependent children
W.V.A.) C.W.A.)	Family	None	Annual	100% Reduction rate on OAS/GIS income after \$15/mo. single, \$30/mo married and other income over \$83/mo. single or \$125 married	\$196 - \$236 (Apr. '75)	Varies with a needs test - most are at maximum
V.P. (1) Veteran O.P.) (2) Widow	Family Family	None None	N/A N/A	N/A N/A	\$461 (Jan. '75) \$345 (Jan. '75)	Varies with degree of disability and family size. Flat rate plus marginal rate for children
G.P.P.: (1) retirement (2) disability	N/A Family	None None	N/A Annual	N/A Transfer income disregard (recipient becomes ineligible when earnings exceed \$195/month)	\$122.50 (max) \$139.35 (max)	Varies with previous earnings Varies with previous earnings and number of dependent children.
(3) widower, -under 65 -over 65	Family N/A	None None	N/A N/A	N/A N/A	\$81.67 (max) \$88.31 (max)	Varies with income of deceased spouse and number of children. Varies with income of deceased spouse ONLY.

APPENDIX V: RATE ASSUMPTION FOR PROJECT II

1. Although most direct cash transfer programs vary the size of payment, the paper has used maximum current (as of March/April 1975) single rates.
2. Extended Care: - \$18.50/day or \$562/month
 - patient pays \$5.90/day or \$179/month
 - OHIP pays \$12.60/day or \$383/month.

 In addition, the patient may pay for:
 - Semi-private - up to \$3.50/day or \$106/month
 - Private - up to \$7.00/day or \$213/month.
3. Intermediate Care - \$15.75/day or \$479/month (patient pays all).
4. Residential Care - \$8.15/day or \$248/month (patient pays all).
 In a Home for
 Special Care
5. Municipal Hostel Average: \$8.30/day or \$252/month
 Minimum: 7.50/day or 228/month
 Maximum: 10.00/day or 304/month.
6. Municipal Homes Average: 12.14/day or 369/month
 for the Aged - Minimum: 6.79/day or 206/month
 Residential Care Maximum: 23.00/day or 699/month.
7. Charitable Home Average: 10.82/day or 324/month
 for the Aged - Minimum: 5.86/day or 178/month
 Residential Care Maximum: 26.00/day or 790/month.
8. Mentally Retarded
 (a) Schedule I \$30.00/day or \$912/month
 (b) Schedule II 24.15/day or 734/month.
9. Community Residence Average: \$15.62/day or \$475/month
 for M.R. Minimum: 7.22/day or 219/month
 Maximum: 23.58/day or 719/month.
10. Adult Group Homes Average: 5.25/day or 160/month
 Minimum: 3.57/day or 109/month
 Maximum: 5.90/day or 179/month
11. Visiting Nurses Average cost/visit - \$9.50

APPENDIX M

REPORT OF THE

INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

PROJECT THREE

An interministry sub-committee of senior financial consultants representing the Ministries of Health, Community and Social Services, Correctional Services and Education reviewed the accounting systems of the various types of residential facilities. The general program and financial information already collected for Project One indicated great divergency in the existing methods of recording and reporting financial information and this fact was again confirmed by the sub-committee. Only very few of the systems provided for recording on a functional basis and there was no standardization even among those.

The sub-committee agreed that an accounting system reporting costs on a functional basis was the appropriate system. (see proposed chart of accounts ~~at~~ the end of this Appendix.) This system should facilitate the provision of accurate, comprehensive information making possible comparisons of standard selected costs of facilities within a designated Target Group and also across Target Groups if desired. The new system would not, of course, be more likely to guarantee the accuracy of individual items any more than other systems, but over a period of use and comparison, cost items should gradually be refined to close tolerances.

The sub-committee further agreed that all residential facilities had similar "basic functions", i.e., building and property, food,

administration, etc. These functions were numbered 1 to 6 on the chart of accounts. Each facility also had a program or services to meet the objectives for which it was established and these were represented by cost units in function 7 on the chart.

Although the basic functions (1-6) would be much more readily comparable than service or program units, it should be possible through experience over time to arrive at comparable unit formulations for both basic and program or service functions (7). Such variations as the employment of a physician or a psychiatrist in one facility, and purchase of service in another, could be gradually absorbed into, and tolerated by the system.

If there were a requirement for a facility to break out its costs by service or program divisions, the functional accounts might be used in the same way for each division by allocation of its functional costs. In this way divisional costing within a facility would be consistent with the overall functional cost system of the whole facility.

The sub-committee believed that the functional accounting system, in addition to providing standard unit cost information, might also contribute to better cost analysis and administration within the facilities. For example, they might make a better informed choice between contracted and internally provided food services, particularly if the experience of other similar facilities were available to them. But in the final analysis such improvements always depend upon the motivation and competence of the administrator. This is of particular

interest when comparing profit-oriented and non-profit facilities when looking at the advantages and disadvantages of these options. Most of the hospitals funded by the Ministry of Health, and the Homes for the Aged funded by Community and Social Services, were provided with unit costs of their various operations in a readily comparable form.

It was noted that a number of categories of residential facilities provide non-residential services, i.e., counselling, after-care, consultation with schools and other agencies, etc. The functions for non-resident services have not been included in the chart of accounts but it should be possible to develop similar functional costs for such services without great difficulty.

The comprehensive and detailed accounting and reporting structures outlined in this report are only suitable for residential facilities with appropriate administrative resources. The benefits of maintaining such a detailed system in the small facilities would not justify the cost. However, the small facilities could continue their current accounting practices and use a summarized version of the functional system to report costs quarterly or half-yearly. The sub-committee agreed that the functional report could be adapted for this purpose without difficulty, but it would perhaps be necessary to offer the administrators more assistance through Provincial financial consulting services.

In further developing the functional reporting system, previous studies should be taken into account such as the joint Health/Community and Social Services Task Force, to provide an inventory of basic information

on institutional care. (submitted November 14th, 1973)

Because residential facilities do not now record costs on a standard functional basis, it has not been possible to fully test this system in all the operating Ministries. However, a similar functional system is being operated successfully in at least one category of residential facilities and the Committee is confident that it will work in the other categories. The first steps taken to establish the functional system throughout the residential facilities considered in this report will not be easy, but its eventual success should provide many benefits in the long term.

The above proposal is an integral part of the Committee report and recommendations. It should, however, be possible to implement the application of the functional chart of accounts independently since the benefits would be valid whether or not the main proposals of the full report are accepted.

The Committee suggests that implementation of the functional chart of accounts should not necessarily require changes in existing accounting practice in the Ministries. We believe that in most cases it merely represents an additional reporting capability that will be of particular use to Cabinet and Management Board.

[illegible]

Saïaries - supervisory (first line)

- 222 -

Employee benefits

Purchased services

miscellaneous supplies

Equipment - operation and maintenance

- replacements

- depreciation (if allowed)

Other

Salaries - supervisor (first line)

- other

Employee benefits

Purchased services

Replacements - bedding, linen

- uniforms

- other

Miscellaneous supplies

Equipment - operation and maintenance

Residential Facilities - Functional Accounting

1. Building and Property - Operation and Maintenance

Salaries - Supervisory (First Line)

- Other

Employee benefits

Purchased services

Heating

Other utilities - gas, electricity, etc.

airbase collection

Taxes

Insurance - plant, boiler, equipment

Long term debt servicing (if allowed)

ment

Buildings and grounds - repairs and maintenance

- replacements

- depreciation (if allowed)

Equipment - operation and maintenance

- replacements

- depreciation (if allowed)

Winter

Applicable in Ministry			
Attorney General	Community and Social Services	Correctional Services	Education Health

Applicable in Ministry

- depreciation (if allowed)

Health

Services

Education

Health

Services

Education

Health

Services

Education

Health

Services

Education

Health

Applicable in Ministry

Attorney General	Community and Social Services	Correctional Services	Education	Health

5. Clothing and Personal Needs

Clothing - purchases

- cleaning

Personal allowances

Funeral and burial

Outline

6. Administration

Salaries - Chief Executive Officer

- other full time

- other part time

- temporary

Employee benefits

Purchased services (specify, e.g. bookkeeping and accounting services)

Advertising and public relations

audit

Insurance - P.L./P.D., etc.

Legal

Office supplies, postage, printing and stationery

Attorney General	Community and Social Services	Correctional Services	Education	Health

7. Program Activities

Salaries Health Services

medical doctors

Psychiatrists

Nursing services

Dentists

Laboratory services

Other

Counseling Services

Social workers

Adjuvants

Child care workers

Cnaɹplains

Psychotherapists

Ctiner

Psychological Services

Psychologists

Psychomatrists

Other

Attorney General	Community and Social Services	Correctional Services	Education	Health

Bank charges

Bank interest (if allowed)

Staff travelling and convention (non-program related)

Training courses (non-program related)

Vehicle operation

Equipment - operation and maintenance

- replacements

- depreciation (if allowed)

Otner

Attorney General	Community and Social Services	Correctional Services	Education	Health

Physicians fees

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APPENDIX N
REPORT OF THE
INTERMINISTRY COMMITTEE ON RESIDENTIAL SERVICES

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continued...

PROGRAM Chronic Care Hospitals

FUNCTION AND ADMINISTRATION

Legislation

- Public Hospitals Act
- Health Disciplines Act
- Health Insurance Act

Administration

- Institutional Operations Branch, Ministry of Health

Description of Service and Groups Served

These institutional facilities are governed by community or religious boards of directors in a pattern similar to active treatment hospitals. Most persons served are 65 years of age or older with chronic health care problems requiring a level of service higher than those of nursing homes or homes for the aged. Some younger persons with chronic health problems related to accidents or birth trauma are also served. In general services are geared to health maintenance rather than cure or rehabilitation and the average length of stay in 1974 was 258 days with a range of about 4 months to 2 years. In addition to domiciliary and dietary services, medical, nursing, physiotherapy, occupational therapy, social work and some laboratory services, etc., are provided.

Supervision and Standards

A number of standards and procedures detailed in the Public Hospitals Act, intended for active treatment hospitals, is used for the chronic care facilities but there is no specific written standard. A group of Provincial consultants are available at the request of the facilities in the various specialties. Past experience also suggests that a team of management consultants with specific expertise in this area of service might be valuable in making better use of available resources.

Interdependent Services and Admission Flow and Control

Chronic care facilities are part of a continuum of service including active treatment hospitals (many also have chronic care sections), nursing homes, homes for special care, homes for the aged and municipal hostels, and to some extent psychiatric hospitals and facilities for the retarded. While physicians make the decision on referral and admission in consultation with the family, there are usually no alternatives because of the deteriorated condition of the patients. In past years changing patterns of health service have

reduced the need for existing beds in many active treatment hospitals and these are now frequently put to use as chronic care beds.

Non-Residential Alternatives

There are no non-residential alternatives except care provided in the patient's own home.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>3220</u>
Total chronic beds in active treatment hospitals (not considered for this study)	<u>3198</u>
Size of Facilities	
20-50 beds = 4 hospitals	51-150 beds = 4 hospitals
151-250 beds = 6 hospitals	251-476 beds = 4 hospitals
Total number of hospitals	<u>18</u>
Total chronic units in active treatment hospitals (not considered for this study)	<u>87</u>
Utilization based on number of days care, 1974	<u>90%</u>
Average per diem cost, calendar 1974	<u>\$36.70</u>

Funding Operating Cost

The Province pays 100% of the operating cost on a monthly basis in advance. Services are insured and patients are not required to make extra payments for standard ward care. If private or semi-private is requested, extra charges are paid by the patient.

Capital Cost

Applications are made by community boards for new hospital beds to the Ministry which uses a guideline formula based on beds per thousand population over 65 years of age in the catchment area. A needs study may be undertaken by the community to document their request and the Province pays 2/3 of this cost. However, whatever the results of the study, the decision rests with the Province.

The Province pays 2/3 of the cost of buildings, renovations and alterations, furnishings and equipment but pays nothing toward the cost of land. Start up fees and pre-opening expenses are included but not working capital. Few communities experience difficulty in raising private funds for this purpose since most municipalities have established a hospital grants policy.

Cost Control

Budgets are submitted annually to the Province for approval and these are reviewed in very great detail in relation to funds available according to the multi-year plan. Year to year increases have been made on a fixed percentage basis but the Province has recently asked the hospitals to put forward their requirements for the year. If they fall within the constraints of the multi-year plan approval is given without further negotiation. If a request is firm beyond the limits set it goes to a review committee and a team of consultants may be sent out to review the development of the budget. This usually results in a reduction to meet the constraints. Considerable pressure is then brought to bear through the monthly financial reports to hold expenditures to the approved budget. Overspending is treated as a cost to the hospital which must be eventually corrected by off-setting savings. Two teams in the financial controls office work on salary and price inflation factors as an information base for the multi-year plan. Some extra funds are allowed for the establishment of new beds based on individual requests well in advance. These funds are then built into the multi-year plan and held firm.

Cash flow is based on net requirements as shown by the monthly financial reports from each facility. Detailed cost comparisons are prepared for use both by Provincial personnel and the hospitals showing 99 items or indices of cost. These are often used informally when cost issues arise and consultation between hospitals takes place to reconcile differences. The Ministry is working toward cost control on a regional basis.

Federal Cost Sharing

The cost sharing formula with the Federal Government under the Diagnostic Services Act returns somewhat less than 50% of the cost of this program.

MAJOR ISSUES AND PROBLEMS

1. A major difficulty in this program is that it serves the same target population as a number of others in Health and Community and Social Services. Some means of unifying funding and program policies should be investigated in order to use available services more rationally and efficiently. Both Hamilton and Ottawa are making an effort to do this locally but Province-wide co-ordination is needed. As a beginning the two Ministries might consider the work being done by the Project Development Group under Dr. J. Aldis in the Ministry of Health.

2. There are both regional and central implications to the issue noted above and before program responsibilities are assigned on a regional basis, consideration should be given to the need for continuing central functions.
3. Indications are that pressure is building up on chronic care hospitals as a result of current restraints which may be eroding the quality of care. However, no clear cut evidence is available at this time.
4. It is suggested that emphasis on public health education might result in more selective use of facilities.
5. The success of some private firms of consultants specializing in hospital administration suggests the need for a similar capability within the Provincial Government to serve a wide variety of consulting needs.

PROGRAM Private Chronic Care Hospitals

FUNCTION AND ADMINISTRATION

Legislation

Private Hospitals Act

Administration

Institutional Planning and Operation Division, Health

Description of Service and Groups Served

These facilities are institutional in style and owned by private corporations. The services and persons served are much the same as Chronic Care Hospitals but at a somewhat lower standard. Supplementing this program are 524 beds temporarily approved for chronic care in Nursing Homes. The significance of the temporary designation is that the beds are expected to be gradually phased out and replaced by chronic care beds in active treatment hospitals. Persons served have chronic health care problems largely in the older age group.

Supervision and Standards

Specific standards written into the legislation are minimal but consultants are available from the Ministry staff in each of the various disciplines and services. It is suggested that standards in some of the hospitals and the temporarily approved beds in nursing homes should be substantially higher.

Interdependent Services and Admission Flow and Control

Most patients are placed direct from active treatment hospitals, nursing homes, homes for the aged and other facilities. Very few move back to other services. There is some suggestion that nursing homes use these facilities to reduce their load of "heavy" nursing care without sufficient reason - as a cost saving measure. Since chronic care is very much more expensive (1975-76 estimates) this presents both policy and cost problems. Placements are generally made on the advice of a physician. Chronic care beds are still being established in active treatment hospitals where reduction in beds related to other services, e.g., maternity, can be made.

Non-Residential Alternatives

There are none except twenty-four hour care in the patient's own home.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974 430
(524 beds also temporarily approved for
chronic care in nursing homes)

Size of Facilities

11-25 beds = 5 hospitals 26-40 beds = 6 hospitals
41-100 beds = 2 hospitals

Total number of hospitals 13

Utilization based on number of days care, 1974 98%

Average per diem cost, calendar 1974 \$36.70

Funding

Operating Cost

The Province pays 100% of the operating cost on a monthly basis in arrears. Services are insured and patients are not required to pay anything more for standard ward care. Extra charges are made for semi-private and private care.

Capital Cost

The Province does not share in the capital cost.

Cost Control

This is based mainly on the review of an annual forecast budget submitted to the Ministry. During the year no formal reporting is required and financial consultants from the Ministry visit on a rotation basis and on request. A year-end audited financial statement is required and the profit level is kept to a maximum of 6.5% of investment. However, the effectiveness of this would depend on salary and expense control as well. According to the financial information received, year to year increases follow much the same pattern as active treatment hospitals.

Federal Cost Sharing

Somewhat less than 50% under the Hospital Insurance Diagnostic Services Act.

MAJOR ISSUES AND PROBLEMS

1. A major difficulty in this program is that it serves the same target population as a number of others in Health and Community and Social Services. Some means of unifying funding and program policies should be

investigated in order to use available services more rationally and efficiently. Both Hamilton and Ottawa are making an effort to do this locally but Province-wide co-ordination is needed. As a beginning the two Ministries might consider the work being done by the Project Development Group under Dr. J. Aldis in the Ministry of Health.

2. There are both regional and central implications to the issue noted above and before program responsibilities are assigned on a regional basis, consideration should be given to the need for continuing central functions.
3. Indications are that pressure is building up on chronic care hospitals as a result of current restraints which may be eroding the quality of care. However, no clear cut evidence is available at this time.
4. It is suggested that emphasis on public health education might result in more selective use of facilities.
5. The success of some private firms of consultants specializing in hospital management suggests the need for a similar capability within the Provincial Government to serve a wide variety of consulting needs.
6. It may be that cost control and program supervision methods should be more stringent - not only to see that funds are being well spent but to determine cost in relation to services given.

PROGRAM

Nursing Homes

FUNCTION AND ADMINISTRATION

Legislation

Nursing Homes Act
Health Insurance Act

Administration

Institutional Planning and Operations Division
Inspection Branch

Description of Service and Groups Served

These facilities are operated as private business organizations on the institutional model providing a minimum of 1½ hours nursing care per day for Extended Care patients and less for "intermediate care". Persons served are generally in the older age group having a broad range of health problems with about 91.5% of them on Extended Care, a coinsurance program under OHIP. The average age of residents is somewhere between 80-85 years. Average length of stay was not available at the time the information was gathered for this report but it may be reasonable to assume that it is similar to Homes for the Aged - about 6 years. Services provided are medical, nursing and personal assistance care with a requirement that each case be reviewed by a physician every three months, particularly with respect to drug prescription and medication. Efforts at reactivation and remotivation of residents include crafts, games, social groups, counselling, etc. The per diem rate for those on Extended Care, standard ward, is fixed by the Province and does not allow for very extensive social programming. Private and semi-private rates are also fixed by the Province for Extended Care but residential rates where residents pay their own way are set by the Homes.

Supervision and Standards

The legislation spells out standards and requirements in detail and regular inspection is provided to see that these are carried out. There are some complaints from the Homes that the Provincial inspectors are too concerned with physical standards and not enough with program. Care standards appear to be generally adequate in the majority of Homes but upgrading is needed in a number of instances. The number of Extended Care beds is regulated at a minimum of 75% of the licensed beds, and 60% of the Extended Care beds must be standard ward care with the remainder 25% semi-private and 15% private. The remaining beds - that is those not designated as Extended Care - are used for

private residents who pay their own way at rates set by the Homes.

Interdependent Services and Admission Flow and Control

Extended Care residents must complete a two-part form, one part themselves and the other by their physicians and signed by both parties. The physician thus decides whether or not the person is eligible. However, because of imbalances in the whole range of care facilities for the elderly, and for financial reasons, many persons are placed on Extended Care who might otherwise be maintained in their own homes. It has been estimated that this could apply to as many as 30%-40% of persons in Nursing Homes.

Non-Residential Alternatives

A number of studies in Canada and observation of services actually established, particularly in the western Provinces, suggests that services like visiting nurses, home help, handyman or woman, meals-on-wheels, house cleaning, visiting, telephone callers, pension, legal and tax counselling, etc., could help many elderly persons remain in their own homes where the majority of them prefer to be. These services are poorly developed in some Ontario centres and virtually not at all in most. Studies suggest the overall cost would be markedly less than institutional care and that cost could be controlled by relating non-residential services to specific groups rather than making them universal.

STATISTICS, FUNDING AND COST CONTROL

Total number of licensed beds to December 31st, 1974	<u>22,875</u>
(Extended Care - 91.5%)	

Size of Facilities

7-25 beds = 109 homes	26-50 beds = 161 homes
51-100 beds = 81 homes	101-200 beds = 42 homes
201-301 beds = 20 homes	

Total number of homes	<u>413</u>
-----------------------	------------

Utilization based on number of days care, 1974	<u>98%</u>
--	------------

Per diem cost to March 31st, 1975

Extended Care Standard	\$17.00
Semi-Private	+ \$ 3.50
Private	+ \$ 7.00

These rates are set by the Province - overall average including payments by private residents is not known.

Funding

Operating and Capital Cost

Since 90% of the operating costs related to standard ward care is based on coinsurance under OHIP and no capital costs are provided by the Province, it can be said that this is the primary source of revenue for Nursing Homes. Add-ons paid by the resident for semi-private and private care are also controlled by the Province as shown in the previous section and the Homes may make discretionary charges only for the non-Extended Care resident.

The Homes submit claims for payment in arrears once monthly based on the number of allowable days care. A resident may leave the home for medical or program reasons for up to 72 hours on the decision of a physician without financial loss to the Home.

Extended Care residents pay \$5.45 for standard ward care and the Province pays \$11.55 through OHIP for a total of \$17.00. If the resident cannot pay all or part of the \$5.45 the municipality pays the difference under the sharing provisions of the General Welfare Assistance Act. Since many of the residents are elderly they would qualify for OAS-GIS-GAINS, Family Benefits, etc.

The Homes must pay the cost of purchase, lease or construction of the building and provide their own working capital.

Cost Control

Quarterly financial and statistical statements are required by the Province as well as a year end audited financial statement. However, regular counts of persons in residence are not done in the field. Otherwise the system is controlled for the most part by the fixed rates and inspections by the various consultants. Books of accounts are inspected in the field on a sample basis.

Federal Cost Sharing

There is no Federal sharing at this time.

MAJOR ISSUES AND PROBLEMS

1. Lack of admissions co-ordination and control allows Nursing Home operators to balance their work load in their own favour, i.e., admitting the less difficult and "lighter" care residents.
2. Classification of levels of care with costs prescribed for each level as proposed in the Recommendations of the Report should allow for more equitable distribution of work load throughout the whole Target Group system and effect better cost control.

3. The provision of non-residential home help and support services might reduce admissions to Nursing Homes substantially providing services at lower cost.
4. There are strong indications that physicians are approving applicants for Extended Care to some extent out of financial considerations when they cannot afford to pay the non-insured resident rates. More precisely defined levels of care and overall co-ordination and control of admissions might also alleviate this problem.

PROGRAM Senior Citizens Residences

FUNCTION AND ADMINISTRATION

Legislation

Charitable Institutions Act
Homes for the Aged and Rest Homes Act
Health Insurance Act

Administration

Senior Citizens' Bureau
Capital Services Branch, Community and Social Services

Description of Service and Groups Served

The institutional facilities in this program serve senior citizens in the over 60 year age group but the average age of admission is about 80. This is an important factor since both the age of admission and the gradually ageing population within the homes has required changes in program to suit persons who are becoming more and more disabled. With the establishment of Extended Care in this program too the population now much more closely resembles the care levels in Nursing Homes and Chronic Care facilities, thus suggesting policy review with reference to future integration.

The facilities are divided almost equally into two groups: the private charitable corporations governed by community, ethnic or religious boards and those operated by the municipalities. As may be expected the municipal homes are more vulnerable to the forced admission of the "heavier" care residents, particularly because of the freedom nursing homes have to control their admissions for profit motives. At the time that Extended Care was introduced into the homes general levels of 60% of the beds in municipal homes and 40% of the beds in charitable homes were set and an effort has been made to maintain this proportion. Because there is a ceiling on the shareable cost of charitable homes (not in municipal homes) the charitable homes need to have a larger group of paying residents, but donations from the community to make up the difference between the Provincial contribution and the total cost are more and more difficult to find.

In addition to the basic nursing, medical, dietary and housekeeping services, activities include a wide variety of interest groups, crafts, resident councils, community trips and other involvement, religious services, chapels, counselling and social services for both residents and relatives. Volunteers often play a large part in the services of the charitable homes. Average length of stay is about 6 years.

All cities, counties, municipalities, districts with populations of more than 15,000 and Indian Bands are required to establish homes for seniors in the legislation. Satellite homes have been introduced in the municipal homes where the healthier ambulatory residents may be

placed in foster care or other residences on a purchase of service basis from \$8-\$14.50 per diem.

Supervision and Standards

There are few prescribed standards in the legislation although there are administrative guide lines for both the residential and Extended Care groups. The Capital Services Branch is developing guide lines for construction and maintenance of buildings and provides the services of a consulting architect. There are Provincial consultants in medical and nursing care, nutrition and administration. These services are of particular value to community groups and municipalities during construction and program planning stages.

Interdependent Services and Admission Flow and Control

Senior citizens homes are part of the continuum of care including nursing homes, chronic care facilities and active treatment hospitals. Most applicants are self-referrals but others come from the whole network of health and social services. Each senior citizens home is fully responsible for its own admission control although the municipal homes tend to have less choice than the charitable homes and are likely to have a larger group of "heavy" care residents. These are further increased by the higher proportion of Extended Care cases established for them at the outset of the Extended Care program.

Non-Residential Alternatives

Although there are many services for senior citizens in their own homes as alternatives to institutional and satellite home care, these have been slow to develop in Ontario relative to the size of the population. Examples are meals-on-wheels, day care, short-term care (vocation care), elderly persons centres, transportation, etc. These services are often given by the homes themselves. The experience of other Provinces and countries suggests that we in Ontario tend to provide strong financial and other incentives for the elderly to go into institutions rather than remain in the community with the aid of support services. A person in a senior citizens home is provided with a \$43 comfort allowance at least (higher if on Extended Care) if on OAS-GIS-GAINS. This amount of discretionary income would not be feasible if a person receiving the same benefits lived in the community in unsubsidized accommodation.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>26,300</u>
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Size of Facilities

12-50 beds = 37 homes	51-100 beds = 43 homes
101-150 beds = 28 homes	151-200 beds = 25 homes
201-250 beds = 18 homes	251-300 beds = 6 homes
301-400 beds = 12 homes	401-500 beds = 5 homes
501-622 beds = 2 homes	

Total number of homes	<u>176</u>
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Utilization based on number of days care, 1974	<u>90%</u>
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Average per diem cost, calendar 1974

Range for various classes of persons	\$12.65-\$21.00
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Funding Operating Cost

The various funding formulae are rather complex and the following are only some of the main features:

Charitable Homes - Province shares 80% of the cost to \$13.50 per diem for residential care. Extended Care residents pay \$5.45 and Province pays \$11.55 - difference between the \$17.00 and actual cost must be paid by Home. Province also pays 80% of that portion of the \$5.45 unpaid by Extended Care residents.

The difference between the Provincial contribution and the full cost of care must be found by the home from full and part pay residents and donations from the community and families of residents.

Municipal Homes - For residential care Province pays 70% of the operating deficit. For Extended Care the resident pays \$5.45 and the Province pays \$11.55. The excess of cost over the total of \$17.00 is shared at 70% by the Province. If the Extended Care resident is unable to pay the full \$5.45, Province shares 70% of the unpaid portion.

Capital Cost

Charitable Homes - Province pays \$5,000. per bed for new construction and \$1,200. per bed for acquired buildings. As an alternative the Province pays 80% of the debt retirement cost in proportion to the number of financially assisted resident days on a monthly basis.

Municipal Homes - Province pays 50% of the approved capital cost.

Cost Control

Charitable Homes - Where a home operates up to the \$13.50 per diem ceiling the Provincial share is controlled by the ceiling. Where the per diem is less than \$13.50 there is very little control other than the 20% share to be raised by the home itself.

Municipal Homes - Since the Province shares the cost of the operating deficit at 70% control is mainly in the ability of the municipality to raise the remaining 30%. Items of \$500. or more must be approved by the Province and also salary rates of supervisory staff.

MAJOR ISSUES AND PROBLEMS

1. Inequities of charges as between Extended Care residents and non-Extended Care residents.
2. Inequities of discretionary income and commitment of assets on entering homes.
3. For seniors living on OAS-GIS-GAINS-Canada Pension Plan, institutional life provides a much higher standard of living. This provides a strong incentive for seniors to enter institutions.
4. Long waiting lists for admission is related to some extent to a severe shortage of support services for seniors living in the community. This also encourages people to enter institutions.
5. Shortage of chronic care facilities puts pressure on physicians to use Extended Care route for seniors who then apply for entry to homes for the aged and nursing homes.
6. Use of satellite homes is left to individual municipal homes rather than being developed more directly by the Province which would be a financial and program advantage.
7. Standards in some homes are too low and there is no legislative authority to require improvement.

PROGRAM Homes for Special Care

FUNCTION AND ADMINISTRATION

Legislation

Homes for Special Care Act
Nursing Homes Act

Administration

Psychiatric Hospitals Branch
Inspection Branch, Ministry of Health

Description of Service and Groups Served

There are three levels of care designated under this program: Extended Care and intermediate care in Nursing Homes licenced also as Homes for Special Care, and residential care in Homes for Special Care residential facilities. All of the beds are reserved for use by persons placed from Psychiatric Hospitals and Mental Retardation Facilities. The age breakdown in Nursing Homes is as follows:

65 years and over	2,372 residents
56-64 years of age	1,139 residents
46-55 years of age	760 residents
36-45 years of age	320 residents
26-35 years of age	254 residents
17-25 years of age	215 residents
16 years and under	152 residents.

Nursing Home Total	5,212 residents	(capacity 5,950)
Residential facilities	total capacity	1,941
(age breakdown not available)		

Total beds	<u>7,891</u>
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Note - On the Summary chart, Appendix C, the 5,950 Homes for Special Care beds are included in the total of 25,000 beds for Nursing Homes. Only the 1,941 residential beds are shown in the Homes for Special Care section. Persons placed in these facilities are not regarded as "heavy care" residents and are considered unable to benefit further from treatment or training in Psychiatric and Mental Retardation facilities. They are generally regarded as "psychologically dead". The organizational description of Nursing Homes appears under the Nursing Homes report. The Residential Homes are generally of the group home type with a small number falling into the institutional category. The Residential Homes are operated by private owners who receive per diem payments of \$7.50 per day from the Province. Residents are expected to participate as far as possible as family members with a minimum of personal care assistance.

Supervision and Standards

The beds in Nursing Homes are, of course, subject to the general standards and inspection practises which the Province applies to Nursing Homes. The Residential Homes have separate standards under the Homes for Special Care Act and are inspected by field workers who are responsible to both the Psychiatric Hospitals Branch and the Inspection Branch. Consultants in the various disciplines are also involved through other administrative centres in the Ministry of Health. The Ministry is currently planning to consolidate the administrative centres for this program. Residents are generally expected to dress and feed themselves. Care guide lines are provided for the Hostesses and the attending physicians. Medication must be reviewed every three months and Hostesses are responsible to see that residents use prescribed drugs appropriately. Residents are covered for the total cost of health care. Only about 65% of residents have discretionary income and where there are no savings or no assistance from relatives they must depend on field worker's distribution of tobacco and personal care items. There is some concern about financial deprivation in a number of cases since no comfort allowances are provided. The assumption that all of these persons have no further potential for improvement has been challenged by community groups, in particular the Ontario Association for Mental Retardation. The Association argues that many could be reactivated and remotivated to lead a fuller life. (See page 4 of Bibliography) The \$7.50 per diem does not allow much leeway for program development although some efforts at improvement are being made.

Interdependent Services and Admission Flow and Control

As already stated Homes for Special Care beds are used exclusively for placement from Psychiatric and Mental Retardation facilities and although they are formally discharged they may be readmitted to those facilities if deterioration takes place. Some may go home or to other placements such as Chronic Care facilities but the total is less than 5% in any one year. Discharges are tabulated once every six months.

Non-Residential Alternatives

There are no non-residential alternatives other than twenty-four hour care in the person's own home.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974:

Nursing Homes	5,950
Residential Homes	<u>1,941</u>
Total beds	<u>7,891</u>

Size of Facilities (Residential only)

1-4 beds = 136 Homes 5-8 beds = 76 Homes
 9-20 beds = 45 Homes 21-30 beds = 12 Homes
 31-50 beds = 3 Homes

Total number of Homes 272

Utilization based on number of days care, 1974 95%
 (Residential only)

Average per diem cost, calendar 1974 \$7.50

Funding Operating and Capital Cost

Extended Care is funded as already described in the report on Nursing Homes.

Residential care in Nursing Homes (called intermediate care) and residential Homes for Special Care are funded by the Province at a fixed per diem of \$7.50.

No provision is made for capital cost or working capital subsidies.

Cost Control

Rates are set by the Province and lists are maintained by the placing agencies of admissions and discharges.

Federal Cost Sharing

There is no Federal cost sharing except for Provincial payments to "persons in need" who are resident in the Homes.

MAJOR ISSUES AND PROBLEMS

1. Provincial program managers suggest that the level of care required is not reflected in the per diem allowed to the Homes - it should be higher.
2. There have been complaints that too many persons are placed long distances from their family homes.
3. There is a shortage of Nursing Home beds in Toronto for the purposes of this program.

4. The larger Residential homes are unable to accommodate the "family living" philosophy of the program and should perhaps be phased out.
5. Financial deprivation is evident for those residents who have no discretionary income or assistance from their families.
6. There is strong feeling in some public quarters that more should be done to motivate and reactivate a section of the population in this program by providing the appropriate increase in staffing levels.

PROGRAM Municipal Hostels

FUNCTION AND ADMINISTRATION

Legislation

General Welfare Assistance Act

Administration

Municipal Welfare Consulting Unit,
Community and Social Services.

Description of Service and Groups Served

There are three types of hostels established under this program:

1. Seasonal hostels set up for summer travellers, mostly overnight accommodation.
2. Emergency care for individuals or families eligible for general welfare assistance. This is short-term accommodation usually not exceeding 15 days.
3. Domiciliary hostels, many of which were previously nursing homes, not now able to meet the licencing standards. Persons in care are frequently those ineligible for nursing homes and homes for the aged or on waiting lists for those institutions, or persons discharged from mental hospitals not eligible for Homes for Special Care. Service provided is basically room and board with very minimal personal assistance. The average stay is about six months.

All but a few of these homes are privately owned and managed under agreement with the municipality on a fee for service basis.

Supervision and Standards

The General Welfare Assistance Act provides no accommodation or staffing standards for this program nor does it provide for supervision by Provincial support staff. A kind of supervision may be carried out by visiting municipal welfare field staff but there are no written standards or operation guidelines. When a municipality enters into an agreement with a newly established hostel, the Province recommends inspection by fire protection and health authorities but has no powers of enforcement. The program manager strongly recommends that these facilities be brought under a proper residential authority with program and financial accountability.

Interdependent Services and Admission Flow and Control

This program was originally intended to provide emergency shelter for general welfare assistance

recipients at the municipal level. Scarce resources in homes for the aged, nursing homes and post treatment residences for the mentally ill have forced admission of more and more disabled persons, thus creating a need for higher care standards. The operators of the domiciliary hostels have expressed some concern about their ability to give proper care to these persons.

Non-Residential Alternatives

Many residents in the domiciliary hostels require twenty-four hour supervision because of mental or physical incapacity and non-residential alternatives would not be appropriate for them. There are significant numbers, however, who might be maintained in their own homes with a minimum of assistance from visiting homemakers and nurses. Such services are available only on a limited basis in the large population centres with Provincial-municipal sharing on an 80%-20% basis. Outside these centres both hostels and nursing and homemaker services are very scarce.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974

Summer hostel beds	approx. 3,000
Emergency hostel beds	unknown
Domiciliary hostel beds	526

Size of Facilities (does not include summer hostels)

2-10 beds = 16 homes	11-20 beds = 18 homes	
21-30 beds = 6 homes	31-40 beds = 5 homes	
41-50 beds = 2 homes	51-100 beds = 3 homes	
Total number of homes		50

Utilization based on number of days care, 1974 Unknown

Average per diem cost, calendar 1974 Unknown.

Note: Municipalities include cost of hostels in the claims for reimbursement to the Province of general welfare assistance expenditures without breaking out hostel costs separately and they are not required to report such figures except at the time when the establishment of the hostel is approved by the Province.

Funding Operating Cost

The Province shares the cost at 80% of the agreed per diem rate. (see note above)

Capital Cost

No capital funds are actually provided for this program although \$1,500. per bed is available under the Act if the municipality provides 20% of the cost of the building. Accommodation is generally owned by private operators who provide the service to the municipality at an agreed fee on a fee for service basis.

Cost Control

Authority for the use of a hostel by a municipality is based on the completion of the necessary form and Provincial sharing is then mandatory. Per diem rates must not be increased without prior discussion with municipal officials. Forms are also completed by residents on admission to the hostels but financial reporting is through municipal channels only and the initial determination of per diem rates and the growth in use of hostels is left almost completely to municipal judgement. Most of the rates are in the \$6.-\$8. range but as pressure mounts to admit the more disabled groups, costs are increasing toward nursing home and homes for the aged levels.

Federal Cost Sharing

This program is shared with the Federal Government under the Canada Assistance Plan at 50% with a return of 30% to the Province and 20% to the municipalities.

MAJOR ISSUES AND PROBLEMS

1. The question has been raised as to whether domiciliary hostels should be governed by the same standards as similar services under The Charitable Institutions Act or other legislation. The program manager strongly recommends such action having expressed serious concern about lack of standards and supervision.
2. Consideration might be given to the expansion of "intermediate care" in homes for the aged, nursing homes, or other special care facilities to serve some of the more needy residents in this program. Current costs of hostels serving such needs are reaching the same level of cost or higher.
3. There is considerable scope outside the large population centres to assist the aged and infirm to remain in their own homes with homemaker or nursing services.

PROGRAM Homes for Retarded Persons

FUNCTION AND ADMINISTRATION

Legislation

Homes for Retarded Persons Act

Administration

Children's Services Bureau, Community and Social Services

Description of Service and Groups Served

These are generally small community based residences sponsored and operated by local community boards incorporated under a non-profit charter, most of which are local associations for the retarded. The legislation has also recently made provision for auxiliary residences in order to provide for more open and independent living where appropriate. Many persons moving on to auxiliary residences would have spent some time in a Home for Retarded to reach the necessary level of social, vocational and personal care skills. These services closely conform to the concept of "normalization" and form an integral part of the comprehensive range of mental retardation services now in development throughout Ontario. Groups served are children, youth and adults.

Supervision and Standards

Homes for Retarded must meet the program and accommodation standards set forth in the Act as well as the requirements of local zoning, fire protection and health standards. The services are further enhanced by the close interest of parents and other members of the community involved in the local associations for the retarded; also by regular consultation with skilled provincial supervisors and co-ordinators with the co-operation of the Ontario Association for the Mentally Retarded.

Interdependent Services and Admission Flow and Control

The sponsoring boards set their own admission policies and procedures and generally admit persons from the Schedule I and II facilities for the retarded and from the open community. The integrated Ontario plan for the retarded with units already established and under development includes:

1. Schedule I, II and III facilities each with associated approved homes and assessment services under the Developmental Services Act.
2. Community based residences and auxiliary residences under the Homes for Retarded Persons Act.

3. Sheltered workshops under the Vocational Rehabilitation Services Act.
4. Developmental day care under the Day Nurseries Act.
5. Protective counselling and family and community support services for persons living in residences and in the open community.
6. Family Benefits Allowances for retarded persons 18 years of age and over.

Non-Residential Alternatives

The Ontario plan with more fully developed protective counselling and family and community support services should make it possible not only for more retarded persons to continue living at home or independently in the open community, but to continue doing so for longer periods of time before residential services become necessary.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>681</u>
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Size of Facilities

10-20 beds = 20 homes 21-30 beds = 10 homes 31-50 beds = 4 homes

Total number of homes	<u>34</u>
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Utilization based on number of days care 1974	<u>95%</u>
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Average per diem cost calendar 1974	<u>\$17.55</u>
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Funding

Operating Cost

The Province pays up to 80% of approved operating cost and the sponsoring corporations make up the remaining 20% from the following sources:

1. Family Benefits Allowance for persons 18 years of age and over.
2. United community funds.
3. Local associations for the retarded.
4. Fees from parents.
5. Municipal grants.
6. Private fund raising.

Capital Cost

The Province pays the lesser of 80% of approved cost of land and construction, acquisition, renovation, addition or alteration, or \$15,000. per bed. The sponsoring corporation may raise the additional amount through general fund raising and donations from parents, municipal grants and legacies and CMHC mortgages. Rent may be included as a part of the operating expenditure in lieu of a capital grant.

Cost Control

In general the cost sharing arrangements between the Province and the sponsoring corporations has provided good service with costs at the low end of the residential services cost scale. Strong support from parents, community and local associations for the retarded and extensive volunteer services have been important factors. Payments from the Province are made monthly based on claim forms related to the number of days care in each month. Forecast budgets and quarterly financial and statistical reports are also required. High rates of occupancy have generally maintained adequate financial support except for northern communities with smaller population bases. Where premises are rented, the lease must be approved by the Province.

Federal Cost Sharing

No cost sharing with the Federal Government is anticipated at this time. However, cost of Family Benefits Allowances to retarded persons in residence is shared at 50% under the Canada Assistance Plan.

MAJOR ISSUES AND PROBLEMS

1. The trend toward establishment of large numbers of community based residences for the retarded will inevitably intensify questions of community acceptance and a good deal of community education and interpretation of the "normalization" concept will need to be done.
2. Existing Provincial financial support of operating costs at 80% is inequitable in that adult residences (18 years and over) are in effect funded 100% by the Province through Family Benefits payments. Residences for children must find the remaining 20% from private sources. However, since there is a much more pressing need for adult services, this inequity may not require urgent resolution.
3. The Ontario plan for broad development of services for the retarded may be hampered by the administrative weakness of local associations who will be asked to

take on much heavier responsibilities. The Province may need to take steps to strengthen them by directing the inclusion of more board members from the community with backgrounds in business and administration. Greater Provincial staff support in the areas of programming and administration will also be necessary.

4. Another issue related to the above is the number of separate program elements coming under the aegis of local boards, e.g., day care, workshops, residences, etc., requiring relationships with a multiplicity of Provincial representatives. Consideration should be given to the unification of these functions in Provincial support staff.
5. More rapid development of the existing community based residences under the Homes for Retarded Persons Act will be closely related to the release of considerable numbers of retarded persons presently in the large institutions. Careful choice and preparation of individuals for the transfer will be very important and this implies effective liaison between the community residences and institutions. If the transfer is to take place fairly rapidly then logistics will also be an important factor. Failure to make proper preparations could result in service breakdowns which might reflect unfairly on the community residence program.
6. In the past local associations for the retarded (mostly parents) and other community groups have volunteered time and money for services. Their energy and drive have been crucial to the establishment of these and other services for the retarded. Because most families retain a close interest in their retarded members, and are willing to help, steps should be taken to maintain and foster this interest.

PROGRAM Adult Group Homes

FUNCTION AND ADMINISTRATION

Legislation

Charitable Institutions Act

Administration

Rehabilitation Bureau, Community and Social Services

Description of Service and Groups Served

These services provide residential care for chronic alcoholics, the physically handicapped and post-release offenders. Emphasis is placed upon return to independent living in the community through the development of independence and self-reliance, personal care and life skills, remotivation toward employment and skills in group living. The physically handicapped who are employed or utilize community resources may require ongoing staff support scaled to the severity of the handicap. The facilities are operated by non-profit corporations through representative community boards who share the cost of the services with the Province. Average length of stay is 8-10 weeks for the alcoholics and offenders and a range of 2 months to 2 years for the handicapped with some requiring very long-term or permanent care.

Supervision and Standards

The responsible corporations set their own policies and service standards and are accountable to the Ministry for overall quality. The legislation also provides minimum accommodation and service standards. In addition written service guidelines are sent to the homes for chronic alcoholics and a data collection system for follow up and program evaluation has been established for use by the homes for alcoholics and the Ministry. Similar data collection procedures will be developed for the facilities for the handicapped and post-release offenders which are also provided with program guidelines. The Ministry makes available the services of a paid rehabilitation counsellor to the homes for alcoholics on a local basis and counsellors or supervisors are also involved with the development of residences for offenders and the handicapped. The prime source of referrals for the halfway houses are the Ministry of Health's non-medical detoxication centres usually associated with general hospitals.

Interdependent Services and Admission Flow and Control

The Ministry approves each home as it is established for one of the three categories of service and monitors the

ongoing service. Day to day operations including admissions are governed either by a committee of the Board, by an admissions committee or by the Director himself. In the case of chronic alcoholics, many are placed direct by the detox centres who have priority on the vacant beds. Evaluation data already available for services to alcoholics will gradually come on stream for the other services and be used partly to control admissions.

A considerable variety of community and government agencies provide support services for these groups in addition to those provided by the Ministry. These include the John Howard and Elizabeth Fry Societies, YM-YWCA, hospitals, detox centres, sheltered workshop and other training resources, handicap action groups, family service agencies, Manpower, GAINS and Family Benefits (the latter two for handicapped only).

Non-Residential Alternatives

There is a range of support services that may be used to assist the three categories of persons in this program to live independently in the community but these apply mostly to the handicapped and then only if they are in an approved training program. The Vocational Rehabilitation Services Act provides physical restorative services and funds for modification to homes (ramps, doorway, bathrooms, etc.) for persons enrolled in an approved training program. The Province also gives financial assistance to municipalities for homemaker and nursing services which are generally available in support of the General Welfare Assistance program. Community services such as drop-in centres and special transportation vehicles for the handicapped are also available in some localities. GAINS and Family Benefits payments are available for those who are eligible. At this time the above services meet only a small portion of the overall need although the cost is much lower than that of residential care.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974

Physically Handicapped	101
Chronic Alcoholics	292
Post-Release Offenders	<u>117</u>
Total	<u>510</u>

Size of Facilities

5-20 beds = 18 homes 21-40 beds = 4 homes 41-85 beds = 2 homes

Total number of homes 24

Average per diem cost, calendar 1974

Handicapped \$11.82

Chronic Alcoholics \$12.24

Post-Release Offenders \$16.06

Funding

Operating Cost

The Province pays 80% of the approved operating cost up to a ceiling of \$13.50. The Province pays in addition 80% of the approved debt retirement cost for accommodation prorated according to the number of financially assisted residents.

Residents who receive GAINS or Family Benefits are required to pay \$5.45 per diem into the homes. These revenues are deducted in calculating the Provincial share of costs. In the one home that has approved extended care beds the residents certified as extended care patients pay \$5.45 per day with the Province paying an \$11.55 flat rate. Residents who are employed and receive salary are required to contribute up to the full cost of the actual per diem.

Capital Cost

The nature of this service results in approved corporations purchasing acquired buildings and using the debt retirement provision of the Act to amortize the capital cost. This method gives them an advantage over the \$5,000. per bed provided under the Act for new construction and \$1,200. per bed for acquired buildings. Another option is under the General Welfare Assistance Act where the Province pays \$1,500. per bed for the establishment of hostels but only if the municipality contributes 20% of the actual cost of the building.

Cost Control

The ceiling of \$13.50 per diem of which the Province pays 80% on the basis of monthly claims after expenditures are made is the major cost control factor. Where per diem costs are below the ceiling the 20% share to be raised by

the sponsoring corporation tends to keep costs from rising to the ceiling. High cost items are usually submitted for approval first but there is no established policy or procedure. In any case unacceptable expenditures may be identified from the quarterly financial report and attached work sheets.

Federal Cost Sharing

The Federal Government shares 50% of the operating cost and debt retirement cost for assisted residents who are the great majority in this program.

MAJOR ISSUES AND PROBLEMS

1. In the case of the physically handicapped there is a conflict between the financial limitations of the Act and the service need to help residents achieve maximum independence. Freedom of choice in living arrangements and disposal of income are essential to move the service in this direction. Rent subsidies and community support services would be very useful in this respect. It is suggested that the physically handicapped of normal intelligence should have freely disposable income at the minimum wage level to provide the freedom of choice associated with the development of optimum self-reliance and independence, e.g. purchase of clothing, independent housekeeping, recreation, etc.
2. The present ceiling on costs under this Act does not allow sufficient funding for the establishment of homes for the more severely physically handicapped persons who are at present inappropriately placed in homes for the aged, chronic care hospitals and nursing homes. In the case of chronic care hospitals per diem costs are much higher than alternative services that might be developed.
3. There has been some discussion about jurisdiction, specifically whether services for post-release offenders should be administered by Correctional Services. There would seem to be a good argument for separation: all offenders in the Corrections stream are under sentence whereas this service is for post-release offenders. Psychologically there appears to be an advantage to allowing a person who has finished his sentence to leave the Corrections stream.

4. Differences in funding of similar services for offenders create conflicts, e.g. the Solicitor General's Department in Ottawa pays a flat rate of \$12.50 per diem, Ontario's Correctional Services pays \$18.00 per diem in the contract homes with additional financial incentives. The homes for post-release offenders under the Community and Social Services program receive 80% of up to \$13.50 per diem.
5. There are a relatively small number of needy persons, socially and emotionally handicapped, who have previously had psychiatric treatment but are not eligible for Homes for Special Care or Nursing Homes. These persons would be receiving Family Benefits or GAINS but would have no support services available to them. Several briefs have come forward from interested community groups asking that homes be established for such persons. Family Benefits and GAINS revenue would offset most or all of the cost and the present Act would provide the necessary authority. It is recommended that such homes be established.

PROGRAM Children's Mental Health Services**FUNCTION AND ADMINISTRATION****Legislation**

Mental Health Act
Children's Mental Health Centres Act

Administration

Institutional Health Services, Ministry of Health

Description of Service and Groups Served

These are private, non-profit, facilities governed by representative community boards in most cases, serving emotionally disturbed children up to 19 years of age or older at the Director's discretion. Average length of stay is about two years. Facilities include a mixture of therapeutic models including institutions, group homes and therapeutic foster homes and out-patient, day care, community services and education programs. In recent years there has been a growing emphasis on direct work with the families of resident children and post-discharge follow up to consolidate treatment gains. A number of facilities also provide day programs and family therapy for non-resident children and support services to schools. In-house education is provided in some facilities for children temporarily unable to attend regular school. An arrangement is worked out with the local boards of education re staffing and supervision and the Ministry of Education pays 100% of the cost. The objective is to return the child to regular school as soon as possible but because of learning deprivation and behaviour problems many children require school readiness instruction, therapy and part-time attendance before beginning regular classes. This approach has helped the staff of a number of schools gain a better appreciation of the management of disturbed children and has improved their teaching skills. While there are variations in philosophy and program emphasis, techniques are generally common to all facilities; children and staff are organized into group living units, balanced in composition to allow for individual needs, in order to achieve maximum benefit from group interaction. Skilled staff supervise and direct programs toward the formation and consolidation of more acceptable behaviour patterns and relationships through the use of group living, physical, social, educational and recreational activities. In order to make better use of and co-ordinate resources in Toronto, a four-phase system is being developed to co-ordinate out-reach, pre-admission, urban and rural treatment and urban re-entry programs.

Supervision and Standards

Though some written guidelines have been developed with others in preparation standards are formulated for the most part through discussion between Provincial program advisers and staff in the facilities. Each adviser is assigned about 12 facilities and a program survey of each facility is completed about once every two years. In the interim consultation is provided as needed in relation to specific problems or developments. Facilities are required to meet local zoning, fire protection, building and health standards but there are not written requirements in the Provincial legislation.

Interdependent Services and Admission Flow and Control

Services are free of charge to the public and placing agencies and staff to resident ratios are high creating a heavy demand for service in most of the facilities. Considerably more than half the children and youth are placed from their own homes with the remainder made up of referrals from children's aid societies, hospitals and correctional services. Some of the facilities have their own school programs for temporary education but close relationships are generally maintained with the schools. Each facility has control over its own admissions. This has led to complaints from other agencies, particularly children's aid societies and Correctional Services, that too few beds are available for their wards. In fact, the actual number placed from these agencies has fallen considerably over the past few years despite an increase in the number of beds. The Ministry is concerned about the control of admissions and has undertaken a survey of children in care. Facilities at present are not required to report reasons for admission, progress of treatment, reason for discharge or actual number of children in residence. These matters are also under consideration by the Ministry. A few facilities are under-utilized because of ongoing program and administration problems.

Non-Residential Alternatives

A number of the facilities operate their own non-residential facilities as part of the overall service administration. These include out-patient services, day treatment programs, family therapy, therapeutic day nurseries, home care, parent training and consultation to schools.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>920</u>
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Size of Facilities

6-12 beds = 7 facilities	13-25 beds = 8 facilities
26-50 beds = 9 facilities	51-302 beds = 2 facilities

Total number of facilities	<u>26</u>
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Utilization based on days care in calendar 1974	unknown
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Average per diem cost in calendar 1974	unknown
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Note: Because of the mixture of residential and non-residential programs the break-out of residential costs was not readily available. The Ministry is now developing an information system with this capability.

Funding

Operating Cost

The Province pays 100% of the total operating cost. Forecast budgets are submitted to the Ministry for each succeeding year on a detailed, standard format. The budget is then negotiated with each facility and when the amount is agreed the facility is paid 1/12 of the total estimate on a monthly basis in advance. Surpluses are adjusted from time to time throughout the year and deficits are negotiated at the year end although these are rare. Expected overexpenditures or surpluses are usually brought to the attention of the Ministry before the year end and a detailed financial statement is required at the end of each calendar year. Quarterly report procedures are in preparation by the Ministry.

Capital Cost

The Province pays 2/3 of the capital cost including land, buildings, furniture and equipment and professional fees and cost of preparation. The total amount to be considered for sharing is negotiated in each case. Rental is shared as part of the operating cost at 100% but the rental agreement must be approved by the Ministry using a market value guideline. Some of the smaller capital equipment items such as vehicles, program and maintenance equipment, education supplies, etc., are included in the operating budget and funded 100% by the Province. In cases where a facility is established on the initiative of the Province the building may be constructed and equipped by the Province with no charge to the user.

Cost Control

Each facility is required to submit an annual forecast budget based on the activity level previously established and approved by the Ministry. Budgets are then negotiated individually in consultation with Provincial financial consultants and program advisers. In the review process particular emphasis is placed on number of staff and salary rates, factors which account for a large proportion of program funds. Both Provincial and local experience are used as guidelines and comparisons are made from facility to facility and year to year within each facility. An important control feature is the set of expectations developed by the Ministry in relation to the facilities and this is reflected in the regular consultation on atypical expenditures initiated by the facilities. At present there are no monthly or quarterly financial or statistical reports.

The Ministry stance on expenditures beyond normal expectations is one of firm constraint. Present weaknesses in control which are shared to a lesser extent by other programs concern admissions, actual numbers in care, allocation of resources within each facility between residential and non-residential services and levels of care actually provided.

A detailed annual statement is required from each facility in conformity with the budget items to compare actual and estimated costs and make the necessary adjustments.

Federal Cost Sharing

No sharing of costs by the Federal Government is anticipated at this time.

MAJOR ISSUES AND PROBLEMS

1. A major problem for these services, especially community based residences, is created by zoning by-laws and community resistance. This is not only true of new facilities but where services are expanded or homes relocated. Directors of facilities are encouraged to develop close relationships with ratepayer groups and neighbours but this is not always successful.
2. Questions continue to come from user agencies, municipalities, politicians and private citizens about the effectiveness of these services in relation to cost. The main reason for this is the difficulty in identifying those elements which justify the higher cost in comparison with similar services in other programs. It is suggested that a comparative study be made.

3. All facilities are fully responsible for setting their own admission criteria and procedures. Data relevant to utilization of treatment resources in respect of numbers actually cared for and levels of care is not yet systematically collected, although the Ministry is planning procedures for this purpose. A few facilities are known to be under-utilized because of ongoing administrative and program difficulties and decisions should be made re de-listing or transfer to other programs. The question was also raised as to whether the Province should give more direction in the allocation of admissions to ensure a balance of placements from all sources and to monitor program effectiveness.
4. Some program guidelines exist but a more fully developed manual is required. Resources should be made available through the Ministry to write the basic requirements as soon as possible. No standards are prescribed in the legislation; facilities meet local health, fire protection, building and zoning by-laws.
5. Mutual problems concerning the learning disabled have been identified and it is recommended that Health and Education set up some administrative mechanism to deal with these more adequately.
6. More services are required for French speaking communities in the eastern townships, the north in general and native families in particular, adolescents, multi-handicapped disturbed and retarded-disturbed children and adolescents.
7. Some facilities have begun to work with families and communities on prevention services as an alternative to residential care. Much more emphasis should be given to this aspect of the work.
8. It is recommended that a formal mechanism be set up to arbitrate financial and program disputes. These are now settled outside existing policy by appeals to politicians and other forms of pressure.
9. Present program costing is considered inadequate to cope with the variety of services within individual facilities. It is recommended that a project be established to improve methods and procedures.
10. Cash flow difficulties arise as a result of budget approval lag. More consistent policy should be developed to maintain payments between budget years.

PROGRAM Children's Institutions

FUNCTION AND ADMINISTRATION

Legislation

Children's Institutions Act

Administration

Children's Services Bureau, Community and Social Services

Description of Service and Groups Served

These services are provided for moderately disturbed children and youth to age 21 and those who cannot live at home because of family breakdown. The facilities include both the community based group home and institutional models and they are operated by representative community boards incorporated under non-profit charters. Length of stay is generally within the one to two year range. Trained and experienced child care staff and social workers provide a broad range of services in order to develop group living skills, positive relationships with peers and adults and a living climate enabling the redirection of maladjusted behaviour toward socially acceptable patterns, in the school, on the job and in social and family situations. Some facilities provide their own classrooms for children unable to attend regular schools but this is intended as temporary and in preparation for regular school attendance. Wherever possible contact is maintained with parents and surrogates and they are involved in the continuing process and planning that eventually leads to reintegration of child, family and community.

Supervision and Standards

Children's Institutions are required to meet both program and accommodation standards under the Act and also local zoning, fire protection and health standards. Provincial supervisors visit regularly as both inspectors and consultants. Many of the residents are wards of children's aid societies and Correctional Services whose field staff maintain contact with the children and thus indirectly perform supervisory and consultative functions.

Interdependent Services and Admission Flow and Control

Admission policies and requirements are individually set by the board of each facility with only minor and informal efforts to co-ordinate services in the area. Children are referred by children's aid societies, Correctional Services, courts and parents and supporting community resources, i.e., education, recreation,

family service and police are used to varying degrees. While the tendency in recent years has been to simulate the family experience milieu a number of placing agencies think this has not gone far enough and for this reason placements have fallen off to some extent. Many senior staff members in these facilities believe that the Province should take a more active role in determining the balance of service and co-ordination of placement. Children's Institutions are part of a network of residential services for children and youth serving much the same target population and they feel there is overlap and confusion because the roles of the various services have not been clearly defined.

Non-Residential Alternatives

It is generally believed that better services for children in their own homes and foster homes would reduce the need for placement in residential facilities. However, appropriate services of sufficient size with effective research support have not been developed to validate this mode. Children's aid societies and Correctional Services have made a beginning in this direction as well as some Children's Mental Health Centres. Again the Province may have a significant role in co-ordinating and directing these efforts since the resources available to any one facility or service are not sufficient to reach conclusive results and the duplication is very wasteful.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>1056</u>
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Size of Facilities

7-20 beds = 21 homes	21-30 beds = 7 homes
31-50 beds = 7 homes	51-114 beds = 3 homes

Total number of homes	<u>38</u>
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Utilization based on number of days care, 1974	<u>80%</u>
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Average per diem cost, calendar 1974	<u>\$22.78</u>
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Funding

Operating Cost

The Province pays 80% of the approved operating costs based on a forecast budget. The sponsoring corporation must raise the remaining 20% of costs, usually from the following sources:

United community funds.

Fees from children's aid societies and Correctional Services paid at 100% of per diem cost.

Court orders on municipalities at 20% of per diem cost.
Municipal grants.

Private fund raising and interest on investments.

Fees from parents up to 20% of per diem cost (very rare).

Capital Cost

The Act provides for \$5,000. per bed for new construction and \$1,200. per bed for acquired buildings. These provisions are now very far from meeting the actual cost of construction and acquisition estimated at around \$15,000. per bed (Homes for Retarded Persons Act). Sponsoring corporations raise their share by private fund raising, municipal grants and legacies.

Cost Control

There is no direct limit on the growth of expenditure in the facilities except informal discussions with Provincial supervisors and financial staff and ultimately the power of the Minister to withhold approval. This method has generally worked quite well, partly because of the sharing arrangements: as the per diem rate rises the 20% share to be raised by the sponsoring corporation increases proportionately. Facilities submit monthly claims based on number of days care and provide quarterly statistical and financial reports as well as annual forecast budgets. In the past couple of years rapidly rising costs and a somewhat reduced number of days care has resulted in considerable deficits in some facilities, and generally, under-financing has become chronic.

Federal Cost Sharing

There is no Federal sharing provided for this program although recent agreements covering services to retarded children and juveniles in the Correctional Services stream may open the door.

MAJOR ISSUES AND PROBLEMS

1. Children's aid societies currently pay 100% of the cost of care. If this were reduced to 20% more intensive and appropriate use of the services would result and also reduce the burden on the municipalities who are complaining about the rising cost of their share of children's aid budgets. The Province would, of course, pay the 80% share and the Institutions would continue to receive 100% of the cost. Since a substantial amount of the added institutional cost would be offset by a reduction in children's aid budgets, the extra cost to the Province would not be great.

2. In relation to the above, increased utilization of Children's Institutions by children's aid societies should improve their revenues and ease the growth of deficits. At this time there is increasing pressure on the Province from the Institutions to increase the 80% share to a higher proportion. Many Children's Institutions regard their services, with justification, as similar to Children's Mental Health Centres whose operating costs are paid at 100% by the Province.
3. The long-term nature of the procedures (about 2 years) to establish a Children's Institution and the low allocation of government funds makes this program unresponsive to community needs. There is a marked tendency for private, "profit-making" services to take up the slack under The Children's Boarding Homes Act and the very low capital provisions tend to increase the effect. This may not be undesirable since the private facilities give generally good service at reasonable cost but a better balance might be achieved by reducing the children's aid payments to 20%.
4. The above issues and problems emphasize the need expressed by many for a more active role by the Province in determining the distribution of placements among children's and youth residential facilities and co-ordinating the development of services across Ministry and Policy Field lines.
5. A number of individual residences and other agencies in the children's services field are experimenting with non-residential alternatives, creating a great deal of confusion and duplication of effort, hence waste. The Province could play a very significant role in co-ordinating these efforts.
6. Following the agreement of the Federal Government to share costs of residential services for retarded children and juvenile delinquents, it should be possible to conclude a similar agreement for Children's Institutions which serve much the same target population.

PROGRAM

Youth Institutions

FUNCTION AND ADMINISTRATION

Legislation

Charitable Institutions Act

Administration

Children's Services Bureau, Community and Social Services

Description of Service and Groups Served

These are generally small, community based facilities, located in residential neighbourhoods. They serve young persons of both sexes sixteen years of age and up who have a wide range of personal and social problems and who are for one reason or another unable to live at home. Length of stay is from a few days to a few months with counselling assistance related to education, employment, personal care problems, relationship problems, etc., and referral to other appropriate resources in the community, e.g., Manpower, counselling services, recreation agencies, etc. Often they provide a "cooling off" period for young people after which they may return to their families or live independently in the community.

The term Youth Institutions is misleading since most of them are on the group home model with the emphasis on fostering independence and social and personal skills. The homes are operated by representative community boards incorporated under a non-profit charter and responsible to the Provincial office for development of program and cost control.

Supervision and Standards

Youth Institutions must meet the program and accommodation standards set forth in the Act as well as the requirements of local zoning, fire protection and health standards. Skilled Provincial support staff visit regularly and are available for consultation on program development and financial problems. There is some overlapping and confusion between these homes and Municipal Hostels with both program and cost implications. A review of this matter is recommended.

Interdependent Services and Admission Flow and Control

Most of the clients in this service are referred by the general network of social, correctional and health services with a small number of self-referrals. The main function of the service is to provide a place to live for short periods during which house staff attempt to redirect the energies of the residents into more

positive and productive channels and connect them with other existing community services to deal with specific problem areas. The immediate goal is for the residents to return to their own homes or to live independently in the community. Admission policies are independently set by the boards of the facilities.

Non-Residential Alternatives

For the most part the clients using this service are too young and inexperienced or too disabled to live on their own with some form of professional support. In fact, the service appears to perform a useful role in giving the young person an opportunity to marshal his or her resources and with counselling assistance to make a fresh start. Without this brief residential respite, personal pressure might well result in more serious breakdown requiring expensive long-term care.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>122</u>
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Size of Facilities	8-24 beds = 8 homes
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Total number of homes	<u>8</u>
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Utilization based on number of days care, 1974	<u>72%</u>
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Average per diem cost calendar 1974 (ceiling @ 80% of \$13.50 prescribed by the Regulation)	<u>\$14.70</u>
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Funding

Operating Cost

The Province provides 80% of the cost up to 80% of a ceiling of \$13.50. The sponsoring corporation raises the remaining 20% from municipal and united community fund grants, private fund raising and an insignificant amount from fees if residents or parents can pay.

Capital Cost

Although the Act provides \$5,000. per bed for new construction and \$1,200. per bed for acquired buildings plus a debt retirement feature, the normal procedure would be to rent the premises and include the cost as part of operating expenditures. Leases must be approved by the Province before they are formally concluded. Since this is not an expanding program recent accommodation trends are not available.

Cost Control

Sponsoring corporations are required to complete monthly claim forms, quarterly financial reports and

annual forecast budgets. However, the \$13.50 per diem ceiling effectively limits the cost of services to the Province. Two of the homes have per diem rates below the prescribed ceiling and in general the cost of service is at the low end of the residential scale. It may well be worth investigating whether this type of service could not be used much more broadly for the many teenagers who are reported by the press almost weekly to be in serious difficulties.

Federal Cost Sharing

These services are shared by the Federal Government at 50% of cost under the Canada Assistance Plan.

MAJOR ISSUES AND PROBLEMS

1. It is recommended that this service be reviewed in relation to other available resources for young persons with a view toward determining its value as one solution to some of the many problems teenagers have today.
2. Most of the homes in this service face increasing financial difficulty and requests for further expansion under the present provisions are not coming forward. If expansion were to be considered as a policy decision, some changes in the funding procedure might be necessary.
3. In some cases there is overlap between this program and Municipal Hostels. It is recommended that this be investigated and clearer distinctions made.

PROGRAM Homes for Unmarried Mothers

FUNCTION AND ADMINISTRATION

Legislation

Charitable Institutions Act

Administration

Children's Services Bureau, Community and Social Services

Description of Service and Groups Served

These facilities serve unmarried, pregnant, adolescent girls and women who require a home in the later stages of pregnancy. Although the demand for this service has fallen with the birth rate in the past few years, there has been a much higher ratio of young, more disturbed girls in the 14-17 year age range. This group requires a skilled service, particularly counselling, and a number of directors of the homes have made representations to the Province to upgrade the capability of the service on this account. Since the homes are under the jurisdiction of The Charitable Institutions Act there is a per diem ceiling of \$13.50 of which the Province pays 80%. One of the homes has recently been transferred to The Children's Institutions Act in order to allow a higher level of funding for services to non-pregnant, disturbed girls as well as pregnant girls. The homes are sponsored by church organizations under non-profit charters and they provide training in infant and personal care, health care, domestic and social skills, education, recreation and counselling. Most of the homes have classrooms and special teachers, many of whom are employees of the local boards of education. Most of the homes are somewhat larger than group homes and the style of service is a combination of group home and institution. In most cases the girls leave the home almost immediately after the birth of their child though some professionals believe that homes should have an after-care capability to train the young mothers in mothercraft and prepare them more adequately for life in the open community.

Supervision and Standards

All homes must meet the prescribed accommodation and program standards in the Act in addition to local zoning, fire protection and health standards. Regular supervision and consultation is provided by Provincial field staff. Because of the major shift in clientele to younger, more disturbed girls, the Ontario Association of Homes for Unwed Mothers has asked the Province to lift the per diem ceiling and allow the homes to develop

programs more consistent with service to disturbed adolescent girls. Since more and more young unwed mothers are keeping their babies, there is widespread concern about the adequacy of mothering and the negative impact on the babies. Of even greater concern is the large number of unwed girls in the community receiving no service whatever and the increasing incidence of young disturbed children from these single parent homes.

Interdependent Services and Admission Flow and Control

Many of the unwed mothers are first seen by social workers in children's aid societies and then referred to homes. Many do not wish to have their babies in homes choosing rather to live with their friends or parents and somehow eke out a living. In this connection it is interesting to note that in the homes with stricter rules about curfew, visiting and general behaviour, utilization has dropped off drastically. A major problem is to motivate the girls to seek help or alternatively develop services, perhaps non-residential, that have more appeal to them. It is generally believed that in the absence of such services many infants are being seriously and permanently damaged by inadequate early care.

Non-Residential Alternatives

As indicated above the majority of unwed pregnant girls and young mothers are not seeking the use of available services. It is of urgent concern from the number on welfare assistance rolls alone, that more effective services be developed. Many of their children are turning up at age one and two in serious difficulty. Abortion has also become a serious issue in relation to the use of both residential and non-residential services.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>284</u>
Size of Facilities	
10-20 beds = 3 homes 21-30 beds = 8 homes 32 beds = 1 home	
Total number of homes	<u>12</u>
Utilization based on days care in calendar 1974	<u>64%</u>
Average per diem cost calendar 1974	
(Province shares only 80% of up to \$13.50)	<u>\$12.60</u>

Funding

Operating Cost

The Province pays 80% of the operating cost up to a fixed ceiling of \$13.50 and the sponsoring church groups raise the remaining 20% from the following sources:

Private fund raising (church groups).
United community funds.
Boards of education (provide teachers in most cases).
Fees from clients and putative fathers.
Municipal grants.

Capital Cost

Although the Act provides \$5,000. per bed for new construction and \$1,200. per bed for acquired buildings and a debt retirement feature as part of the operating cost over and above the \$13.50 ceiling, no call has been made on these funds in recent years. Because of the lowered birth rates and lack of demand for the services as they are now constituted, new homes for unwed mothers are not likely to be established in the near future.

Cost Control

Because of the \$13.50 ceiling on per diem rates and the shortage of private funds, costs will probably increase very slowly. In fact, more than half the homes already have per diem rates higher than the ceiling and ongoing inflation will likely erode program effectiveness or bring about closure of some homes.

Federal Cost Sharing

This program is shared at 50% of Provincial expenditure under the Canada Assistance Plan.

MAJOR ISSUES AND PROBLEMS

1. The clientele served appears to be much younger in recent years and requires more skilled help than is available in most of the homes for unmarried mothers.
2. Many practitioners in the homes for unwed mothers believe much of the existing program should be converted to services for disturbed adolescents and also continue to serve unwed mothers.
3. Practitioners believe services should also be developed for unwed mothers and their babies where

the young mothers can be cared for and trained in mothercraft at the same time.

4. The utilization of facilities in some homes has fallen off so drastically that it would seem appropriate to close them or convert to other uses. Many pregnant girls who might use the services are not doing so.
5. It is recommended that a review of the problem of unwed mothers and their babies be undertaken to determine the future course of service for this group.

PROGRAM

Children's Boarding Homes

FUNCTION AND ADMINISTRATION

Legislation

Children's Boarding Homes Act

Administration

Children's Services Bureau, Community and Social Services

Description of Service and Groups Served

These facilities serve children and youth up to age 18 covering the full range of disabilities, mental, emotional, social and physical. The bulk of the services are comprised of units of 12 beds or less styled on the group home model. The Homes are nearly all established and maintained through informal agreements with placing agencies - usually children's aid societies on a fee for service basis - and are operated by private persons or companies, a few of these holding non-profit charters. Thus, the Homes can be set up very quickly with a minimum of procedural delay and the program has proven to be very responsive to the needs of placing agencies. The Homes have played a vital role in filling service gaps left by the programs funded direct by the Province. In most cases the operators are well known and trusted by the placing agencies as a result of previous experience either in those agencies or other residential services for children and youth. In any case the relationships between these Homes and placing agencies are generally more positive, perhaps because they are completely dependent on the placing agency for their income. Despite this, concerns have been expressed about standards of care and a need for closer supervision by Provincial staff is indicated.

Supervision and Standards

Perhaps because of the proprietary nature of these services and the somewhat lower standard required by the Act compared to funded children's and youth residences, they have been more vulnerable to public criticism. In fact, it would seem that standards are not dissimilar but the "profit motive" appears to be an added irritant. It would be a mistake, however, to exaggerate this; both Provincial supervisors and placing agencies are generally well pleased with the services and a considerable number of them are able to cope with seriously disturbed children at about half the cost of treatment centres established for the purpose. There is also a tendency for them to be responsive to suggestions about program development and show strong motivation to provide a quality service. Furthermore, since they are generally small

and dependent, they are much more ready to please placing agencies which reduces bureaucratic conflict and rivalry. Accommodation, staffing and books of account requirements are set forth in the Act and local zoning, fire protection and health standards must be met before Provincial registration is granted. Provincial supervisors visit at least once a year in connection with the annual re-registration; if there are problems, visits are more frequent. The field workers of the placing agencies visit the children for whom they are responsible and this is also an important supervisory element. An annual statistical report is required.

Interdependent Services and Admission Flow and Control

Admission is controlled to a large extent by the children's aid societies using the Homes and if dissatisfaction with the service arises a Home may be put out of business by the withdrawal of children or refusal to make further placements. Because they are dependent on the good will of placing agencies and host communities, operators tend to be sensitive to public opinion and work closely with municipal councils, police, schools, merchants and neighbours, as well as social and recreation agencies. They are of course "in business", hopefully to stay, and often own substantial amounts of property in the locality which enhances their desire to develop local good will and co-operation in the long term. This in turn lends an aura of stability and community to the services which is of value to the children.

Non-Residential Alternatives

Most of the children and youth placed in these Homes have already had one or more failures in some setting other than their own homes, e.g. children's aid foster homes or group homes, training schools or Correctional Services group homes or foster homes, treatment centres, etc. Non-residential alternatives would therefore not be appropriate and should be used much earlier in the development of the problems.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974 1054

Size of Facilities

4-12 beds = 70 homes 13-30 beds = 17 homes 31-80 beds = 3 homes

Total number of homes 90

Utilization based on number of days care, 1974 95%

Average per diem cost, calendar 1974 \$22.82

Funding Capital and Operating Cost

There is no direct funding of these services from any level of government; residences are operated as private businesses for the most part with a small number holding non-profit charters. Fees for service from the following sources meet full capital and operating costs:

Children's aid societies
Correctional Services special rates
Court orders on municipalities
Private placements (insignificant number).

Cost Control

The per diem rates and fees charged are established by the private operator in each case. Placing agencies have limited funds from Provincial and municipal sources and this exerts some control on the upward movement of per diem costs and program expansion. Homes must compete in the open market with funded services and this also is an important control factor. Rise in fees has generally kept pace with salary and other costs and per diem rates are generally competitive although there are some criticisms of inadequate services. It is important to note that similar criticisms are directed to other services such as Children's Mental Health Centres and others which are funded at a much higher level by the Province at 100% of cost.

Federal Cost Sharing

Most of the cost of care of residents placed in these Homes is already shared under the Canada Assistance Plan through other programs, viz., Child Welfare, Correctional Services, Family Benefits.

MAJOR ISSUES AND PROBLEMS

1. Because most of the facilities in this program are owned and operated by individuals, are "profit-making" and for the most part very small, they are especially vulnerable to criticism. Although many are operated by persons with considerable experience in residential service and are able to give a good deal of attention to each of the few children in their care, they are sometimes criticized for lack of staff resources. These criticisms are at variance with the opinions of the placing agencies who regard most of the services highly. Furthermore,

the great variety of services allows for maximum use of special skills. Costs are comparatively low to meet the restricted budgets of placing agencies but criticisms are still made about high cost relative to service given in some cases.

2. Criticism of the Province for not providing a sufficient number of trained field staff to supervise and support these services appears to have some justification. Many cannot be visited more than once a year.
3. Variations in per diem rates within the program are also a matter of concern as part of a much broader issue about variations in the cost of residential care. It has been suggested that a scale of fixed rates be set for these services but it would appear that this would also entail control of placement. Otherwise, there would be a tendency for services to opt for the top end of the fee scale.
4. Some practitioners believe that these privately financed services have definite advantages. The staff are thought to be more co-operative, to provide more program flexibility and make more efficient use of available staff, plant and equipment. Also the program is far less costly for the Province to administer and should for a number of reasons be considered a viable alternative to the further development of funded programs.
5. Zoning restrictions are a particular concern to this group because of their vulnerability to public criticism. Written material and Provincial staff should be made available to discuss concerns with municipalities, ratepayer and neighbourhood groups.

PROGRAM Homes for Retarded Persons

FUNCTION AND ADMINISTRATION

Legislation

Homes for Retarded Persons Act

Administration

Children's Services Bureau, Community and Social Services

Description of Service and Groups Served

These are generally small community based residences sponsored and operated by local community boards incorporated under a non-profit charter, most of which are local associations for the retarded. The legislation has also recently made provision for auxiliary residences in order to provide for more open and independent living where appropriate. Many persons moving on to auxiliary residences would have spent some time in a Home for Retarded to reach the necessary level of social, vocational and personal care skills. These services closely conform to the concept of "normalization" and form an integral part of the comprehensive range of mental retardation services now in development throughout Ontario. Groups served are children, youth and adults.

Supervision and Standards

Homes for Retarded must meet the program and accommodation standards set forth in the Act as well as the requirements of local zoning, fire protection and health standards. The services are further enhanced by the close interest of parents and other members of the community involved in the local associations for the retarded; also by regular consultation with skilled provincial supervisors and co-ordinators with the co-operation of the Ontario Association for the Mentally Retarded.

Interdependent Services and Admission Flow and Control

The sponsoring boards set their own admission policies and procedures and generally admit persons from the Schedule I and II facilities for the retarded and from the open community. The integrated Ontario plan for the retarded with units already established and under development includes:

1. Schedule I, II and III facilities each with associated approved homes and assessment services under the Developmental Services Act.
2. Community based residences and auxiliary residences under the Homes for Retarded Persons Act.

3. Sheltered workshops under the Vocational Rehabilitation Services Act.
4. Developmental day care under the Day Nurseries Act.
5. Protective counselling and family and community support services for persons living in residences and in the open community.
6. Family Benefits Allowances for retarded persons 18 years of age and over.

Non-Residential Alternatives

The Ontario plan with more fully developed protective counselling and family and community support services should make it possible not only for more retarded persons to continue living at home or independently in the open community, but to continue doing so for longer periods of time before residential services become necessary.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>681</u>
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Size of Facilities

10-20 beds = 20 homes 21-30 beds = 10 homes 31-50 beds = 4 homes

Total number of homes	<u>34</u>
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Utilization based on number of days care 1974	<u>95%</u>
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Average per diem cost calendar 1974	<u>\$17.55</u>
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Funding

Operating Cost

The Province pays up to 80% of approved operating cost and the sponsoring corporations make up the remaining 20% from the following sources:

1. Family Benefits Allowance for persons 18 years of age and over.
2. United community funds.
3. Local associations for the retarded.
4. Fees from parents.
5. Municipal grants.
6. Private fund raising.

Capital Cost

The Province pays the lesser of 80% of approved cost of land and construction, acquisition, renovation, addition or alteration, or \$15,000. per bed. The sponsoring corporation may raise the additional amount through general fund raising and donations from parents, municipal grants and legacies and CMHC mortgages. Rent may be included as a part of the operating expenditure in lieu of a capital grant.

Cost Control

In general the cost sharing arrangements between the Province and the sponsoring corporations has provided good service with costs at the low end of the residential services cost scale. Strong support from parents, community and local associations for the retarded and extensive volunteer services have been important factors. Payments from the Province are made monthly based on claim forms related to the number of days care in each month. Forecast budgets and quarterly financial and statistical reports are also required. High rates of occupancy have generally maintained adequate financial support except for northern communities with smaller population bases. Where premises are rented, the lease must be approved by the Province.

Federal Cost Sharing

No cost sharing with the Federal Government is anticipated at this time. However, cost of Family Benefits Allowances to retarded persons in residence is shared at 50% under the Canada Assistance Plan.

MAJOR ISSUES AND PROBLEMS

1. The trend toward establishment of large numbers of community based residences for the retarded will inevitably intensify questions of community acceptance and a good deal of community education and interpretation of the "normalization" concept will need to be done.
2. Existing Provincial financial support of operating costs at 80% is inequitable in that adult residences (18 years and over) are in effect funded 100% by the Province through Family Benefits payments. Residences for children must find the remaining 20% from private sources. However, since there is a much more pressing need for adult services, this inequity may not require urgent resolution.
3. The Ontario plan for broad development of services for the retarded may be hampered by the administrative weakness of local associations who will be asked to

take on much heavier responsibilities. The Province may need to take steps to strengthen them by directing the inclusion of more board members from the community with backgrounds in business and administration. Greater Provincial staff support in the areas of programming and administration will also be necessary.

4. Another issue related to the above is the number of separate program elements coming under the aegis of local boards, e.g., day care, workshops, residences, etc., requiring relationships with a multiplicity of Provincial representatives. Consideration should be given to the unification of these functions in Provincial support staff.
5. More rapid development of the existing community based residences under the Homes for Retarded Persons Act will be closely related to the release of considerable numbers of retarded persons presently in the large institutions. Careful choice and preparation of individuals for the transfer will be very important and this implies effective liaison between the community residences and institutions. If the transfer is to take place fairly rapidly then logistics will also be an important factor. Failure to make proper preparations could result in service breakdowns which might reflect unfairly on the community residence program.
6. In the past local associations for the retarded (mostly parents) and other community groups have volunteered time and money for services. Their energy and drive have been crucial to the establishment of these and other services for the retarded. Because most families retain a close interest in their retarded members, and are willing to help, steps should be taken to maintain and foster this interest.

PROGRAM Children's Aid Society Residential Services

FUNCTION AND ADMINISTRATION

Legislation

Child Welfare Act

Administration

Children's Services Bureau, Community and Social Services

Description of Service and Groups Served

These are community based residences (excluding foster homes) generally housed in normal family-type dwellings serving boys and girls to age 18. Most of the children are wards of children's aid societies but a small number are placed in care with the consent of parents as non-wards. Wardship is granted by the juvenile and family courts where children up to age 16 are judged to be in need of protection or who require services parents cannot provide. Facilities include reception and assessment, parent and staff operated group homes and a few treatment facilities. Length of stay ranges from a few months to 5 years or more.

Supervision and Standards

The residential services under consideration here are integrated within the general administration of each children's aid society with assigned supervisory and management staff. There are no prescribed service or building standards although the facilities are required to meet local fire, health, zoning and building regulations. Individual children in the residences are assigned to a children's aid social worker's caseload and the worker visits the child on a regular basis. There is also a senior worker responsible for the operation of the home and the service standards are the joint responsibility of the workers and supervisors. Provincial supervisors visit regularly to discuss children's aid services including the residential services. These services have generally been free of public criticism and have received favourable comment from the communications media.

Interdependent Services and Admission Flow and Control

All of these facilities are used for children in the care of children's aid societies. The societies also use many other residential facilities under Community and Social Services and Health legislation. A number of these children become wards of Correctional Services through infractions of the law. Most of the children come from

children's aid foster homes or their own homes referred by schools, hospitals, police and many other agencies. Some are returned from the other residential services mentioned above after a period of care. Technically, children's aid societies have no control over admissions since these are decided by the court in most cases. Children's aid workers and supervisors decide on the type of placement and length of care in residence except where the judge assigns the child to a specific facility.

Non-Residential Alternatives

The major methods used as alternatives are to provide counselling for children and parents in their own homes and to give extra support to such homes, i.e. homemakers, babysitting, week-end relief and direct child care work in the home. Such programs have developed very slowly for lack of funds and expertise. They would have to be much more freely available before their success as alternatives could be adequately evaluated.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>1550</u>
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Size of facilities

6-8 beds = 215 homes	9-24 beds = 20 homes
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Total number of homes	<u>235</u>
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Utilization based on number of days care, calendar 1974	<u>75%</u>
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Average per diem cost, calendar 1974	\$18.00
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Funding

Operating Cost

The formula for sharing children's aid costs between the Province and the municipalities in each children's aid jurisdiction results in considerable variation from one jurisdiction to another but the Provincial average for 1974 was 70% Provincial and 30% municipal. This also represents the approximate cost sharing of residential facilities under The Child Welfare Act for the Province as a whole.

Capital Cost

Most children's aid residential facilities owned by the agencies were purchased with private funds, usually in

the form of donations and legacies, without Provincial sharing. However, a considerable number are rented either by the group home parents or by the children's aid and in this case a rent factor would be included in the operating cost. Where the home is owned by the group home parents the rent factor is lower since the cost of rent is shared by the group home parents. Of the 235 homes the breakdown is as follows:

Owned by children aid	55 homes
Rented by children's aid	61 homes
Owned by group home parents	91 homes
Rented by group home parents	28 homes
Total	235 homes

Cost Control

The Child Welfare Act provides for the Minister's approval of each children's aid budget for the calendar year ahead. Costs of both children's aid operated homes and purchased residential services are given. However, since the societies have no direct control over admissions some flexibility is allowed. Furthermore, provision is made in the Act for payment of the overall budget deficits and recapture of surpluses. Supervision and consultation by Provincial financial supervisors is carried out through regular visits in the field. The Act also provides for direct participation of elected municipal representatives on the boards of directors of each children's aid society. Costs of children's aid residential services are often criticized by municipal officials and in the press but adverse criticism is almost always related to purchased services rather than services operated by the societies. Because services are provided free by the Health sector (Children's Mental Health Centres and hospital units), there is considerable pressure for admission to these services in order to bring down children's aid costs.

Federal Cost Sharing

Federal sharing under the Canada Assistance Plan is calculated on the difference between children's aid costs in the base year 1964 and the current budget year. Although costs on behalf of Indians are shared on a much higher percentage basis, the average Federal sharing is approximately 62.5% of total Provincial payments to children's aid societies.

MAJOR ISSUES AND PROBLEMS

1. A lack of clear definitions of children's aid service objectives and benefits may create pressures for the expansion of residential facilities.
2. The demographic peaking of teenage population places a heavy burden on foster care facilities which are more suited to younger children. This results in greater demand for residential services.
3. The general decline of foster homes thought to be caused by low remuneration and low status of foster parents contributes to the demand for residential care.
4. The difficulty of finding suitable group home parents and accommodation, particularly in the large urban centres, has resulted in the use of more costly residential services.
5. The development of the Children's Mental Health Centres under the Ministry of Health with free service to the general public has resulted in a reduction of treatment beds available to children's aid societies, thus aggravating the shortage for teenagers.
6. Professional trends have resulted in an overall growth in demand for group home services, with the juvenile and family courts playing a major role, i.e. preference of group homes to training schools.
7. There has been some professional criticism of children's aid group home standards in that they are not required to meet the same standards as other residential facilities.
8. There have been considerable misgivings among professionals concerning the division of responsibility for residential services for children among so many authorities with the resulting service barriers, overlaps and variations in costs and staffing patterns.
9. The general failure of children's aid societies to develop effective services to children and parents in their own homes has contributed to the growing emphasis on long-term supervision of children in residential facilities. A major review of the role of children's aid societies is indicated.

PROGRAM Training Schools**FUNCTION AND ADMINISTRATION****Legislation**

Training Schools Act
Juvenile Delinquents Act (Federal)

Administration

Juvenile Division, Correctional Services

Description of Service and Groups Served

Though the traditional image of training schools as jails for children persists in the public mind, programs in many instances have established modern techniques of child care and may be compared favourably with other services for children. The two DARE projects at Portage and Wendigo use the "outward-bound" approach and White Oaks Village at Hagersville is in fact a treatment facility on the group home model. Many changes have been made in the other facilities and the momentum of improvement continues. However, sheer size, emphasis on security, and isolation from the community are major factors yet to be overcome, as well as the attitudes of some of the older line staff. The Group Home Program is becoming a significant alternative and may well become a major factor in the years ahead. Children are committed to training schools by family court judges and usually remain wards until age 18 but the average length of stay has dropped in the last few years from 18 months to 3-5 months. Other placements and return to the community with after-care support services are the major alternatives. Admissions have fallen off very rapidly in the past year or so as a result of the broader range of options open to the courts and the development of Youth Bureaus in police departments. It is estimated that only 19% of juveniles in trouble with the police are actually taken to court with many of the remainder being referred to voluntary agencies. The main focus of training schools is academic education and vocational training supported by a wide range of interpersonal, social skills and recreation programming. The schools follow the guidelines of the Ministry of Education and are regularly inspected by their officials. The regular programs are enriched by activities such as film-making, inter-school public speaking, outdoor education and a variety of educational tours. Some children attend local community schools. Recreation programs are emphasized for reasons of general health, manual skills and personality development. Activities include most outdoor and indoor sports both in the institutions and the community, crafts, theatre, cabaret nights, camping, tripping, volunteer work, community inter-league sports, dances, anti-pollution campaigns, "miles for millions marathons" and community church attendance. Chaplains are members of the professional team taking part in assessment, group counselling and pastoral

counselling in addition to their regular duties in conducting religious services and providing religious education. A work study program has been developed for wards 16 years of age and over involving one quarter to one third of this group in the training school population. The program includes preparation for job interviews, deportment on the job, etc. Where enough jobs are not available in the community young people are placed as volunteers partly to gain on-the-job experience and even younger children participate. At Kawartha Lakes School almost every girl in residence gets some work experience and they are encouraged to send money home. This program has a marked effect on the self-esteem and self-confidence of the wards.

Supervision and Standards

Standards are spelled out in the Act and procedural manuals and regular inspections are made by Ministry staff, representatives of the Fire Marshal, health inspectors and grand juries. Staff are members of the civil service and are required to attend staff training courses and to have regular performance appraisals. Newer staff members have appropriate backgrounds in education and experience.

Interdependent Services and Admission Flow and Control

Children can only be committed by a judge of the family court and in most cases they are first assessed by the Reception Assessment Centre in Oakville where they remain for about six weeks or more in some cases for classification, medical and dental examinations and treatment, clothing, etc. A number are sent from Oakville to alternative placements. In some locations training schools perform their own reception and assessment functions. Thought is being given to overall decentralization of reception and assessment on a regional basis. After a period in training school children are placed in foster homes, group homes, special rates homes and treatment centres, or returned home with the support of after-care officers. Regular family visits on week-ends are common and some family counselling services are provided.

Non-Residential Alternatives

The main alternatives are home placement or independent living in the community with after-care support services. Police youth bureaus play a major role in keeping children out of the corrections stream.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	Boys	925
	Girls	377
	Total beds	<u>1302</u>

Size of Facilities

36-60 beds = 4 facilities 114-155 beds = 9 facilities

Total number of facilities 13

Utilization based on number of days care, 1974

Boys 75%

Girls 93%

Average utilization ??

Average per diem cost to April 1st, 1974 \$42.65

Funding Operating and Capital Cost

The Province operates the schools and provides 100% of the capital and operating costs.

Cost Control

Very detailed scrutiny of costs is made with frequent financial reporting and regular on-the-spot inspection of accounts.

Federal Cost Sharing

The Federal Government shares 50% of the cost of this program on the Canada Assistance Plan model through the Appropriations Act 1974.

MAJOR ISSUES AND PROBLEMS

1. Community involvement of children needs to be increased as part of the "normalization" process. Isolation of most schools is a major obstacle. The stigma of delinquency has been somewhat moderated but is still a problem.
2. Section 8 of the Training Schools Act is under study with reference to diversion of children considered to be unmanageable in their own homes. One alternative is to place them in the care of children's aid societies through some formal mechanism.

3. If the age under the Federal Juvenile Delinquents Act is raised to 17 years and eventually to 18 years as proposed, larger numbers of this age group will be made wards of training school as an alternative to incarceration in adult facilities. Both the numbers and the age will pose new challenges to the program.
4. There is a suggestion that work with families should be much increased by non-correctional services such as children's aid societies in preparation for successful return of children to the community.
5. It is suggested that interagency co-ordination be developed for the pre-delinquent group involving teams from police, children's aid, schools, probation, etc., as a major preventive measure.
6. Treatment services under the Children's Mental Health Service program of the Ministry of Health are not sufficiently responsive in admission of training school wards.

PROGRAM Correctional Services Group Homes

FUNCTION AND ADMINISTRATION

Legislation

Training Schools Act

Administration

Group Homes Branch, Correctional Services

Description of Service and Groups Served

These community based, contract Group Home facilities were established in recent years by the Ministry to add a needed dimension to the existing services for children and youth. The homes are set up on a contract basis with individual home owners who have had previous experience in residential service. Children and youth served range in age from 7 to 18 who have been committed to care by a judge of the Provincial Court, Family Division. Most of the residents have emotional and behavioural problems in much the same pattern as residents of the other facilities for children and youth in the Province. Youngsters are placed in the contract group homes as an alternative to training school placement and also as an alternative to foster homes and special rates facilities, i.e., treatment centres. The special rates and foster homes are not part of this program; they are probation and after care responsibility. Services are also purchased for 264 of this age group in foster homes and 52 in special rates homes on a fee for service basis. Average length of stay is 9 months to one year.

Supervision and Standards

A detailed procedure manual is provided for the guidance of group home staff covering many aspects of care and the relationship between the homes and the Ministry support staff. (see bibliography) It is understood as part of the contract that the procedures will be followed. Each home is provided with a Ministry liaison officer who usually visits once a week. The officer is responsible for long-range planning for the children, is involved in admission and separation decisions and is generally responsible for the maintenance of adequate service standards. He is also responsible for the professional development of group home staff and leads training sessions with the support of the program consultants from the Branch. Each home is linked with a Training School providing opportunities for two-way staff consultation. The Group Home must submit a report to the Central Advisory Committee on each child every three months and also when changes in status are planned. Ultimately the plan is to decentralize the Advisory Board within the established regional organization in order to reflect local variations. An ongoing information gathering and research component is built into the program.

Interdependent Services and Admission Flow and Control

Wards are selected by the Oakville Assessment Centre and individual Training Schools for placement in the group homes. Some criteria used are: low security risk, need for adapting to family setting, potential to benefit, need for development of closer personal and community relationships and lack of alternative resources. Most of these children and youth have had a number of previous placements in settings other than their own homes and were finally committed by the courts when other resources failed to help them. One outcome of group home placements which poses a problem is the paradox of a "normalized" setting housing only residents in conflict with the law. The program manager would prefer a balance of residents including those from other service streams. As it is, the homes carry the juvenile delinquent label.

Non-Residential Alternatives

Since these children are placed intentionally in the group home program for the benefit expected, non-residential alternatives do not apply.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>240</u>
Size of Facilities 5-10 beds = 32 homes	
Total number of homes	<u>32</u>
Utilization based on number of days care, 1974	<u>85%</u>
Average per diem cost, calendar 1974	<u>\$19.50</u>

Funding

Operating Cost

Per diem rates are set by the Ministry and paid 100% by the Province on a renewable contract basis. There is a range allowing for four levels of care: \$17.00, \$18.00, \$21.00 and \$30.00. Utilization incentives are provided by calculating the cost on less than the total number of beds, e.g., in an 8-bed home the cost of operating would be calculated on 6 beds allowing the operator a 2-bed margin if he can keep the home full. In addition, approved amounts are paid for clothing, medical, dental and prescription drug costs, special education and recreation needs, some staff development costs, and mileage allowance for transportation of wards.

Capital Cost

All of the homes are owned by the group home operators and the Province makes an allowance for set-up costs of \$700. per bed for the total number of residents.

Cost Control

Per diem rates are set from time to time by the Ministry based on annual budget submissions from each home and expenditures are monitored on an ongoing basis by Ministry program staff.

Federal Cost Sharing

The cost of this service is shared by the Federal Government at approximately 50% under the Canada Assistance Plan.

MAJOR ISSUES AND PROBLEMS

1. At present correctional services group homes admit only Training School wards which tends to stigmatize them as homes for juvenile delinquents and to some extent undermines the "normalization" process.
2. Although zoning restrictions and objections by neighbours are still a problem, some improvement has been noted, partly as a result of more careful choice of location. Good relationships have been developed with schools and communities have shown an increasingly responsible attitude. There is, however, a continuing job of interpretation to be done.
3. Group homes are being tested by the Ministry as a major alternative to Training School but it will be some time yet before there is sufficient experience to determine the optimum balance of resources.
4. It is suggested that more effective service may be achieved in the larger group home by a reduction in the number of resident beds.

PROGRAM Juvenile Detention Centres

FUNCTION AND ADMINISTRATION

Legislation

Provincial Courts Act

Federal Juvenile Delinquents Act

Administration

Assistant Deputy Attorney General - Administration

Description of Service and Groups Served

There are two models used in this program: larger centres in Windsor, London, Hamilton, Toronto and Ottawa, staffed by civil servants as part of the operating budget of the Ministry, remaining 19 homes and jails are similar in some respects to purchase of service group homes except for the addition of security features. The group home models are sponsored by chartered non-profit community organizations at the local level. While the primary purpose is a holding place for children awaiting the disposition of the courts - implying a very short term of stay - some of the homes are used as rehabilitative group homes for example in Oshawa and Kingston where the stay might be a number of months. While the children are awaiting a hearing the court may request information for a variety of purposes to assist the judge in making a disposition in the best interests of the child and society, or to work out a plan to maintain the child in the community.

Most of the children are placed in these facilities by the police and the courts with a smaller number placed by children's aid societies who may use the detention centre as "a place of safety" in the meaning of The Child Welfare Act. Children are in the age range 7-15 years and most of the facilities admit both sexes. Facilities are located on a regional basis related to the Family Division courts but jails are still used in a number of jurisdictions.

Larger facilities may include education, recreation, interest groups, crafts, community visits, counselling, etc., but the emphasis is on observation and security. A few children may even attend community schools. For the most part the stay is too short to develop significant programs with a rehabilitation component.

Supervision and Standards

The judge in each jurisdiction oversees the operation of the facilities. Many of the staff are untrained and inexperienced. Some have had previous experience in child and adult correctional institutions. There are no standards written into the legislation and no guide lines. No one with specific residential care experience is employed by the Ministry to inspect the facilities and this task falls to the Chief Judge who is unable to

give appropriate attention to it and to the Grand Juries. In general the standards of The Children's Boarding Homes Act are followed.

Interdependent Services and Admission Flow and Control

Placements are made by the police, the courts and children's aid societies, some of which use the centres as a "place of safety" in the meaning of The Child Welfare Act. From these centres dispositions are made by the courts through the Training Schools Act and the Juvenile Delinquents Act affording a wide range of options from probation to all types of residential facilities and placement in the care of children's aid societies. The length of stay has been considerably reduced over recent years.

Non-Residential Alternatives

There are no alternatives at this point but the Chief Judge is considering a project to test the "Sacramento" concept of "home detention" where the child would stay at home under the supervision of a person appointed by the court. This could be of particular value near the locations of Community Colleges where students could be used in the projects as part of their field training assignment. The concept has already been tested in the Kingston "Achievement St. Lawrence Project" and a report is available through the office of Chief Judge Andrews.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>202</u>
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Size of Facilities

2-10 beds = 18 facilities	11-17 beds = 3 facilities
45 beds = 1 facility	

Total number of facilities	<u>22</u>
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Utilization based on number of days care, 1974	<u>39%</u>
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Average per diem cost, calendar 1974

Institutions	\$50
Jails and Group Homes	\$27

Funding

Operating and Capital Cost

Centres at Windsor, London, Hamilton, Toronto and Ottawa are staffed by the Ministry which provides 100% of the operating cost. The Ministry of Government Services builds or leases premises at 100% of capital cost and maintains them. Group home type facilities and jails are on a purchase of service basis with the per diem negotiated individually according to general guide lines. There are no provisions for capital cost in these facilities.

Cost Control

Cost control for this program other than Ministry operated centres is not well developed. Regular forecast budgets were instituted for 1975/76 for the group home type facilities. Periodic financial reporting is mandatory for the Ministry operated centres.

Federal Cost Sharing

None is anticipated as long as these homes are administered by the Attorney General.

MAJOR ISSUES AND PROBLEMS

1. There is a need for specific standards and guide lines and regular supervision by a person experienced in children's residential programs.
2. Jails should be eliminated as juvenile detention facilities and the name of the program changed to Receiving and Observation Centres.
3. A social worker should be attached to each facility to act as a program consultant, investigate the home environment of the children and perform a liaison function with their parents and the other agencies involved.
4. A project to test non-residential alternatives, specifically detention in the child's own home under supervision - the Sacramento concept of "detention without walls" is being planned by the Chief Judge. The plan would include general use of students from Community Colleges whose voluntary services would be a course credit in field placement. The Chief Judge is encouraging judges in the various jurisdictions

to test this concept.

5. Regional Centres should be established in Kenora, Thunder Bay, Sudbury and Barrie.

PROGRAM Residential Schools for the Blind and Deaf**FUNCTION AND ADMINISTRATION****Legislation**

Education Act

Administration

Special Education Branch, Ministry of Education

Description of Service and Groups Served

The Ministry of Education operates three coeducational residential schools on a regional basis for the deaf, and one for the blind, serving children and youth in the age range 5 to 21 years for the deaf and 6 to 21 years for the blind. A number of deaf-blind persons are also served. Services for the deaf may be categorized under five headings: instruction, student services (counselling, health, recreation and off-school hours program), support services (office, laundry, food, maintenance, gardening, etc.) and direct services to children and parents (off-campus). Direct services to parents and pre-school deaf children in their own homes include advising parents on optional methods of training, handling problems in the home, etc. Consultation is also provided to school boards on regular classroom programming and placement resources.

The services for the blind are somewhat different in that direct services to parents and blind pre-school children are provided by the Canadian National Institute for the Blind and the Ministry provides a teacher training program.

As far as possible deaf and blind children are included in the programs of ordinary schools and as school capabilities develop only the more difficult and multi-handicapped children are streamed to the residential schools. Disability-related emotional disturbance is a significant factor among these children. In addition to teaching staff the residential schools employ counsellors (child care staff), social workers, psychologists, speech therapists and audiologists. The children attend the residential schools for 200 days of each school year spending the summers at home.

Supervision and Standards

There are very few written standards for this type of school with the American experience providing limited reference to class size only. Generally the operating standards of the schools are grouped around instruction, health and well being, safety and recreation with emphasis upon the development of self-reliance and

independence in the children. The program manager has been accumulating data on the experience of the schools in preparation for written standards and guidelines in the future. Standards are presently maintained through professional supervision in each area of service.

Interdependent Services and Admission Flow and Control

The Deaf

The primary difficulty is in early detection of deafness in children because parents do not clearly understand the symptomatology. Another difficulty is in diagnostic services. While the Hospital for Sick Children in Toronto is active throughout the Province with the use of a mobile audiology clinic (public health units are also helpful), very few other hospitals have this capability. The Canadian Hearing Society does some of this work and parent groups are active in the dissemination of information and education in the community. The adult deaf are also organized and lobby for improved services. Lions Clubs and the Council for Exceptional Children are also active. Academic researchers are becoming interested in the problems of the deaf and the Federal Government recently provided a grant to establish a national consortium for the study of deafness. Specialist physicians have been very helpful but general practitioners have shown very little interest. The residential schools have volunteer auxiliaries who arrange sports competitions with other high schools, etc. The Canadian Hearing Society also sponsors drop-in centres and recreation services. Beyond the residential school program, the Rehabilitation Bureau of the Ministry of Community and Social Services pays for extended education at the community college level or other training programs. The University of Carleton in Ottawa operates a day nursery for deaf children.

The Blind

The Canadian National Institute for the Blind plays a major role in providing services in co-operation with the Province. Screening and assessment of sight disabilities are made in addition to those done by specialist physicians. CNIB also provides a home-visiting service in co-operation with local boards of education. The Province provides large print books and supplies for the partially sighted but not lenses. About 300 low vision students in Ontario are affected. Every year or two week-end teacher training programs are offered to local boards of education in addition to ongoing consultation. The Superintendent of the Residential School for the Blind is closely related to CNIB through several board memberships. The students attend Cub groups in the community. Admissions to the Residential Schools are at the discretion of the Superintendent. The blind children who can use ink

print are generally accepted in regular school programs and those who must use braille are admitted to the residential school. In some few cases children are placed in local group homes and foster homes and attend the residential schools as day students.

Non-Residential Alternatives

Admission to regular school programs with the associated support services mentioned above constitute the major alternative to residential school services. As the capabilities of the regular school system are extended this more costly care should be kept to a minimum.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>1372</u>
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Total number of day students to December 31st, 1974	<u>301</u>
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Size of Facilities

195-382 beds = 4 institutions

Total number of institutions	<u>4</u>
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Utilization based on enrolment of live-in students, 1974	<u>63%</u>
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The unused capacity is explained by a number of factors:

1. The capability to serve all students requiring residential care must be available.
2. Fluctuations in enrolment are caused by the growing capacity of regular schools to accommodate deaf and blind children with family and community support services.
3. The availability of transportation in recent years has enabled the schools to increase the number of day students.

Note: Extra space available with lower enrolment allows more space to increase program effectiveness.

Average per diem cost calendar 1974

Blind	\$39.40
Deaf-blind	\$53.40
Deaf	\$44.30
Deaf day students	\$30.50

Funding

Operating Cost

The superintendent of each school prepares a budget for the coming year and submits it to the program manager according to prescribed guidelines. After consideration within the Ministry budgets are processed through Management Board and final figures are set for the year.

Capital Cost

The Ministry of Government Services erects the buildings and is responsible for alterations, renovations, furnishings, furniture and equipment.

Cost Control

There is a monthly report to the Ministry of expenditures and variances and a very detailed scrutiny of budget items according to established guidelines. The schools use the common object code in conformity with Ministry accounting practise. Any variance in the monthly report must be accompanied by explanatory notes. The program manager is working toward the development of a system based on cost per pupil. This would entail proportionate allocation of all costs related to the pupil throughout the school on up to supervision of staff and professional development.

Federal Cost Sharing

There is no Federal cost sharing anticipated for this program in the near future.

MAJOR ISSUES AND PROBLEMS

1. The four residential schools are the only residential services administered wholly by the Ministry of Education. They are thus isolated to a considerable degree from the mainstream. It is recommended that closer links be developed with other residential services in Health and Community and Social Services so that the schools may be administered against a broader background of residential experience.
2. As a long term objective it is suggested that de-institutionalizing these services be considered along the lines of small group home units on the family model served by a central education core. This would greatly enhance the learning of social and personal skills vital to the success of the instruction program and the future independence and self-reliance of the students. It would also increase the flexibility of the program; as enrolment fluctuates units could be either increased

or decreased. A closer approximation of family living might also motivate both staff and students to try harder for regular school placements.

PROGRAM Jails and Detention Centres**FUNCTION AND ADMINISTRATION****Legislation**

Ministry of Correctional Services Act
Prisons and Reformatories Act

Administration

Executive Director, Adult Programs,
Correctional Services

Description of Service and Groups Served

These are institutional facilities generally intended as pre-sentence holding units or for serving short-term sentences. The legal limit on length of stay is three months though this may be extended for longer periods by the courts after a short period of freedom and further incarceration. The average length of stay for 1974 was 13.7 days. Persons 16 years of age and over who are charged by the police with an offense under the criminal code or a Provincial statute, or under the Immigration Act and are unable to obtain bail, may be held. For persons under 16 years of age, usually those who commit a serious offense, courts may make a specific order that they be held in a jail or detention centre. Specific services are limited by the brief length of stay but education, recreation, life skills, provision for visits from family and friends, legal aid, sports grounds and equipment, chaplaincy and social services, and classification counselling in preparation for transfer to other facilities, are provided. Medical and dental services are provided for persons serving a sentence. Prisoners may also work in the community if they are eligible for the Temporary Absence Program in which case they pay \$20 per week for board and lodging.

The facilities are operated by Ministry staff and both staff and services have been considerably upgraded in the past few years. Volunteers are recruited and trained by the Volunteer Programs Branch and play a significant role in many of the services. Jails are gradually being replaced by detention centres on the cottage system with more direction to community involvement and normalization.

Supervision and Standards

The specific standards in the legislation and some twenty-six manuals govern service operations in considerable detail and these are kept scrupulously up to date. The Ministry Branch responsible for inspection and standards is directly accountable to the Assistant Deputy Minister of Operations and personnel visit regularly to inspect all aspects of facility operations.

Interdependent Services and Admission Flow and Control

While the main emphasis is on the internal services and procedures there is liaison with police, courts, hospitals, psychiatric facilities, community colleges, etc. The longer term plan is to provide small community based facilities for selected prisoners but this will require much public education to achieve community acceptance.

Non-Residential Alternatives

The non-residential alternatives involve the courts, and probation and parole services and include bail, probation, parole, intermittent sentence and the Temporary Absence Program.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>2731</u>
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Size of Facilities

12-50 beds = 27 jails	51-100 beds = 10 jails
101-150 beds = 4 jails	151-654 beds = 2 jails

Total number of jails	<u>43</u>
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Utilization based on number of days care, 1974	<u>80%</u>
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Average per diem cost, calendar 1974	\$28.43
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Funding Operating Cost

There is a heavy seasonal fluctuation in the use of these facilities and of course they have little or no control over admissions. Annual budgets are estimated on past experience by the facility and reviewed in the Ministry where the final figure for each year is decided. Cost is borne 100% by the Province less the as yet insignificant contributions made for board and lodging by prisoners on the Temporary Absence Program.

Capital Cost

Facilities are built or leased by the Ministry of Government Services and a good part of the maintenance costs are offset by the work duties of the inmates.

Cost Control

A monthly expenditures report in line-by-line detail is submitted by the facilities. Complement must be approved. Budgetary control is very strict creating some counter-productive rigidities. Central purchasing also creates problems by supplying inappropriate items, time lag, etc. However, there is reasonable flexibility in the use of the overall budget amount and budgets are very rarely overspent despite many unpredictable costs caused by wide fluctuations in admissions.

Federal Cost Sharing

No Federal cost sharing is expected at this time.

MAJOR ISSUES AND PROBLEMS

1. Rejection of facilities by the community creates location problems especially in respect of rehabilitation and reintegration of prisoners.
2. There is much ambivalence in the public mind as to whether the emphasis should be on punishment and security or rehabilitation. Thus both this and the former issue require a major effort toward public education.
3. Although bail reform has shortened the length of stay there is still a very major problem of delay caused by bottlenecks in the courts.
4. Rigidities in cost control and central purchasing result in frustration on the part of institutional staff and counter productivity.
5. The more open concept of the community oriented programs require more staff and the present freeze on complement is a major obstacle.

PROGRAM Correctional Centres**FUNCTION AND ADMINISTRATION****Legislation**

Ministry of Correctional Services Act

Administration

Executive Director, Adult Programs,
Correctional Services

Description of Service and Groups Served

Persons aged 16 years and over who are sentenced to two years less a day normally go to these institutional facilities. Those with longer sentences go to Federal prisons. Younger men 16-23 years of age are usually enrolled in the Adult Training Centres which are part of the system and men with shorter sentences may be referred to bush camps to work with the Ministry of Natural Resources. Generally there are considerable opportunities for education and recreation and toward this end links have been developed with the Community Colleges. Prisoners are placed near home as far as possible so that the Temporary Absence Program may be used to the greatest advantage and to facilitate visiting. Facilities range from the more "open" to the less open and placements are made according to the classification of individuals: type of offense, number of offenses, age, social and economic status, etc. Training programs are prevention oriented.

The general position of the Ministry is that inmates should be provided with the kind of training and treatment that will afford them better opportunities for successful personal and social adjustment in the community. Staff has been upgraded - more community college graduates are being employed with greater emphasis on developing helping relationships with prisoners.

New institutions now have no more than 200 beds and use the cottage concept to allow for more privacy and get away from the "institutional" atmosphere. This is a good and improving range of services and a better attitude on the part of staff with respect to rehabilitation. Average length of stay was 137 days.

Supervision and Standards

The specific standards in the legislation and some twenty-six manuals govern service operations in detail and these are kept carefully up to date. The Ministry Branch

responsible for inspection and standards is directly accountable to the Assistant Deputy Minister of Operations and personnel visit regularly to inspect all aspects of operation.

Interdependent Services and Admission Flow and Control

This is a key area of concern for the main body of the Committee's Report and it was therefore thought valuable to include a description of the Ministry's new Classification System. It is quoted as follows.

"In September, 1972, it was decided that the present Classification System for Adult Offenders should be subjected to review and study. A committee was, therefore, formed of newly appointed Regional Administrators under the Chairmanship of the Executive Director of Adult Programmes to undertake this review.

One of the recommendations of the Task Force Report was that classification should be looked at as, "a continuous process," embracing the time an individual is placed under our care at sentencing until he has returned to his community upon release.

At the present time, the Ministry's Adult Correctional Facilities provides for approximately 2,500 offenders, age 16 and over, serving sentences of less than 2 years less a day. Within our offender population, personality types range from tractable, well motivated persons to violent, assaultive individuals to whom crime is a completely acceptable pattern of behaviour. In order to cater to such a diversified population, a careful assessment must be made of individual needs so that each individual can be subsequently placed in an appropriate programme. Our classification system, therefore, endeavours to place the individual sentenced by the Courts in an Institution that is appropriate to his needs in terms of work capabilities, learning potential and treatment requirements. This is done centrally at two locations, Main Office and at the Ontario Correctional Institute, Brampton-Assessment Unit.

CLASSIFICATION CRITERIA

A number of factors have to be considered in reaching the decision as to which Institution Programme an inmate is to be assigned. Among these factors are his age, the length of his sentence, the factors contributing to his anti-social behaviour, his rehabilitative potential,

"treatment requirements, his ability to participate in academic, trade or vocational programmes and the area of the Province from which he came.

ADULT INSTITUTIONS

At the present time, our Adult Institutions are broadly classified for first offenders or recidivists. In addition, specific institutions are classified as open, medium or of a maximum security nature. Individuals are centrally classified at Main Office or the O.C.I. Brampton and assigned to Institutions on the basis of their ability to participate in the programmes offered yet provided the degree of security needed to ensure that they would remain at the Institution. Our Adult Institutions consist of the following:

(1) Adult Training Centres

The educational focal point of Adult Institutions is the training Centre. These centres are designated to accommodate young adults, age 16 to 24, who are generally more responsive to Adult Educational Programmes and the overall rehabilitative efforts of our correctional plan. In each institution the programme includes social, spiritual, recreational, academic and vocational training with counselling offered individually or in groups. Various trades and academic grades are offered at each training centre.

(2) Correctional Centres

Recidivists (18 to 24) are assigned to correctional centres if they are unable to participate in the more open programmes of Adult Training Centres. These centres vary from completely open Institutions for inmates who can function in an open setting to medium and maximum security Institutions. The emphasis on programmes in these centres is towards, maintenance, industry and trade activities. These programmes have been selected for Correctional Institutions in an effort to implant good work habits and provide useful work experience so that the man may return to his community and take up employment on release.

(3) Forestry Camps

The Ministry's Forestry Camps provide a completely open setting for men considered capable of accepting the responsibility such freedom entails and who are able to profit from the healthy and invigorating environment. The outside life also encourages a more meaningful

"relationship between the inmate and staff than is normally possible in other types of settings. At each camp 40 inmates from parent institutions are permitted to serve the last few months of their sentences in this setting.

(4) Jails and Detention Centres

Jails traditionally were used to hold in custody those persons awaiting trial and those who were convicted and sentenced to short jail terms, i.e., under three months duration. Jails were considered to be maximum security institutions. While retaining the remand function a new role was given to jails in the rehabilitation of inmates when the Ministry of Correctional Services took over the responsibility for jails in 1968. At the present time, we are replacing old jails with Detention Centres which have minimum and maximum security features. They permit a person serving sentences of up to three months a wider variety of individual programmes better suited to their needs than was formerly offered in the old jail setting.

(5) Clinics

Within the Ministry special clinics are available. Inmates with Neuro-Psychiatric problems, addictive problems of Alcohol and Drugs and certain types of sexual offenders are assessed and may receive assistance and treatment during their sentences. The Ministry has two Reclamation Centres for Alcoholics where individuals sentenced by the Courts under the terms of the Liquor Control Act may be sent directly upon sentencing.

All Correctional Institutions at the present time participate in the Temporary Absence Programme wherein selected individuals are permitted to attend academic or vocational training or work at gainful employment in the community. Also all Correctional Institutions encourage volunteers from the Community to participate in our programmes to assist inmates towards their rehabilitation.

FUTURE TRENDS

An extensive building programme to replace old outmoded Institutions has been taking place for the last few years and will be continuing. New modern Institutions will permit us to try challenging, innovative treatment and training programmes.

"As an example of the above, the Ontario Correctional Institute at Brampton, in addition, to providing clinical treatment for chemical abuses (alcohol and drugs) and certain types of sexual offenders has an assessment unit which is being used to initially assess and classify first incarcerates from the southern half of Ontario, age 16 to 24 years of age with sentences of six months or more. On completion of the assessment, a Committee chaired by the Main Office Classification Officer selects an Institution for each individual assessed, based upon:

- (a) his treatment needs
- (b) his ability to participate in vocational, academic or trades training.
and
- (c) his ability to participate in Volunteer and Temporary Absence programmes in Institutions close to his home community.

While not all Institutions have classification counsellors and Institution Assessment Committees, it is our intention to ensure that once an individual is initially classified for an Institution, based upon the criteria set out above, every institution will have an Institutional Assessment Committee who will select with the individual an appropriate programme to assist him during his sentence. His programme would be continually reviewed by the Committee and changed as required to meet the individual's needs. Throughout the whole process, the importance of the information to be provided by correctional and professional staffs upon which decisions can be made affecting any individual's programmes or reclassification will be stressed.

As more and varied programs are developed, it is hoped that inmates, on their initial appearance before Institution Assessment Committees will become more involved in the selection of the type and duration of programs which they see as being profitable to them during their sentence."

Non-Residential Alternatives

The non-residential alternatives involve the courts, probation and parole services and include bail, probation, parole, intermittent sentence and the Temporary Absence Program.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>2910</u>
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Size of Facilities

120-250 beds = 7 facilities 251-350 beds = 3 facilities
 351-810 beds = 1 facility

Total number of facilities	<u>11</u>
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Utilization based on number of days care, 1974	<u>78%</u>
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Average per diem cost, calendar 1974	\$29.68
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Funding	Operating and Capital Cost
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There is a seasonal fluctuation in the use of these facilities and of course they have little or no control over admissions. Annual budgets are forecast for the forthcoming year based on past experience and submitted for review by the Ministry where the final figure is decided. Capital and operating cost is borne 100% by the Province less the as yet insignificant contributions made for board and lodging by prisoners on leave in the Temporary Absence Program.

Cost Control

A monthly expenditures report is submitted in line-by-line detail for review by the Ministry. Complement must be approved. Budgetary control is very strict and over-spending is rare. Budgetary control and central purchasing create some counter-productive rigidities.

Federal Cost Sharing

No Federal cost sharing is expected at this time.

MAJOR ISSUES AND PROBLEMS

1. Rejection of facilities by the community creates location problems especially in respect of rehabilitation and reintegration of prisoners.
2. There is much ambivalence in the public mind as to whether the emphasis should be on punishment and security or rehabilitation. Thus both this and the former issue require a major effort toward public education.

3. Although bail reform has shortened the length of stay there is still a very major problem of delay caused by bottlenecks in the courts.
4. Rigidities in cost control and central purchasing result in frustration on the part of institutional staff and counter productivity.
5. The more open concept of the community oriented programs require more staff and the present freeze on complement is a major obstacle.

PROGRAM Community Resource Centres**FUNCTION AND ADMINISTRATION****Legislation**

Ministry of Correctional Services Act

Administration

Executive Director, Adult Services, Correctional Services

Description of Service and Groups Served

Community Resource Centres are small, home-like, community based facilities used as an added program dimension for adults under sentence in detention and correction centres. Prisoners placed in these group homes are eligible for the Temporary Absence Program taking into account personal suitability, type of crime, progress made while in prison, acceptability in the homes and ability to benefit from employment, education and life skills training in the community. The facilities are used for both short and longer term placement with the onus on the individual to perform according to the rules and to benefit from the more open style of life. Prisoners who do not make progress or show good reason to continue are returned to prison. Centres are set up by Ministry agreement with private individuals or incorporated community groups on a contract basis. The program is geared to the development of independence and self-reliance in each individual and rules and regulations are applied accordingly.

Supervision and Standards

Facilities are subject to inspection by the Inspection and Standards Branch of the Ministry and also by responsible line staff. They must comply with local health, fire protection, building and zoning by-laws. Certain program and accommodation standards are also part of the written agreement with the Ministry and each Community Resource Centre is linked with a Correctional Centre. There are no supervision or standards requirements written into the legislation.

Interdependent Services and Admission Flow and Control

The Volunteer Programs Branch of the Ministry is to play an increasingly important role in helping the residents to use the available resources of the local community for the learning of life skills such as purchase of clothing and other personal care items, domestic duties, use of libraries and recreation facilities and preparation for employment. The use of available services in Manpower, community colleges, AA groups and the Addiction

Research Foundation is also emphasized with the assistance of house staff and volunteer counsellors.

Prisoners make application for admission to the homes and the application is reviewed by a committee in the detention or correctional centre. Factors considered are personal suitability related to the past behaviour of the individual and how he will fit into a particular home. If the placement does not succeed the prisoner is returned. Even though Resource Centres are related to a particular Correctional institution, others who have suitable candidates are encouraged to apply.

Non-Residential Alternatives

This program serves prisoners under sentence and therefore non-residential alternatives are not pertinent.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>127</u>
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Size of Facilities

6-12 beds = 12 homes

Total number of homes	<u>12</u>
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Utilization based on number of days care, calendar 1974	<u>75%</u>
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Average per diem cost, calendar 1974	\$18.00
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Funding

Operating Cost

The per diem cost is established by the Ministry to cover operating costs at an operating capacity somewhat less than 100%. House operators are thus encouraged to fill all their beds as a means of earning more revenue. A flat rate is paid to the operator on a weekly basis depending on the size of the home. A fixed amount for each resident over the agreed number is paid in addition.

Capital Cost

Limited capital funds are provided for the establishment of homes in the form of payment for expenditures of up to \$2,500. per home for fire protection renovations and equipment and up to \$525. per bed for other essentials.

Cost Control

Payments are made to the homes at a fixed rate and the books and resident log entries are examined by Ministry auditors and other supervisory personnel. The Ministry also keeps its own record of placements. Homes are free to raise additional funds privately for development of facilities or program beyond the requirement of the Ministry. Any resident who is employed must contribute \$4. per day from his earnings and this amount is retained by the operator of the home partly as an incentive to move residents into employment as soon as they are able to work.

Federal Cost Sharing

No Federal cost sharing is anticipated at this time.

MAJOR ISSUES AND PROBLEMS

1. This program has been in operation for one year and is considered to be successful as an alternative to prison. Only two prisoners of more than a hundred placed have been returned to prison.
2. Local community groups have sometimes reacted negatively to the location of Community Resource Centres in their neighbourhoods and this will likely be a continuing problem. However, as the program develops, publicity about its success may offset this rejection to some degree. To date no serious problems have arisen as a result of the behaviour of the residents.
3. If the program is to achieve its objective in assisting prisoners to achieve social reintegration, local resources in the communities where Resource Centres are located will have to be used more effectively.

PROGRAM Psychiatric Hospitals and Approved Homes**FUNCTION AND ADMINISTRATION****Legislation**

Mental Health Act
Mental Hospitals Act
Children's Mental Hospitals Act

Administration

Psychiatric Hospitals Branch, Ministry of Health

Description of Service and Groups Served

Psychiatric hospitals provide treatment as an insured service for persons with acute mental illness on a regional basis with each hospital serving a specified catchment area. In the catchment areas psychiatric hospitals share this responsibility with those active treatment hospitals which have psychiatric wards and appropriate support resources are allocated to these hospitals as required. Active treatment hospitals are encouraged to develop psychiatric treatment capabilities. This shift in responsibility is regarded as a major improvement in the treatment of the mentally ill since the outcomes in many cases depend on the patient's own perception of his illness. In simplistic terms a patient treated in a general hospital is much less likely to think of himself as permanently impaired and stigmatized than if he is treated in a psychiatric hospital. Furthermore, a change in auspices for the psychiatric hospitals themselves from the Province to community boards is currently under consideration by the Ministry.

At present the psychiatric hospitals are owned by the Province and staffed by civil servants. They provide treatment for the whole spectrum of mental illness in the population. They function as optimal resources in each region and at the same time encourage the development of alternative psychiatric services. Services include most of those found in a well developed general hospital and those that are related to psychiatric treatment and rehabilitation, including out-patient clinics and assessment.

Although there are still instances of long-term care where the patient is a danger to himself and the community, the emphasis is on short-term, voluntary treatment; the current average length of stay is less than 35 days. In recent years treatment beds have been substantially reduced in number and the freed space turned over to rehabilitation and support services. A number have also been used to set up units for the retarded from the overcrowded Schedule I facilities but this is regarded as an inappropriate use and

alternatives are being considered.

Approved Homes

This program is intended for patients who are ready to leave hospital but require a further period of preparation before return to normal life in the community. A detailed manual of policy and procedures for the selection and use of approved homes for patients from psychiatric hospitals and mental retardation facilities is published by the Ministry. The homes are approved by the Minister on the recommendation of the hospital administrator and usually supervised and supported by the social service department of each facility. The homes must meet the fire safety standards of the Homes for Special Care Act and local health standards. They are approved in three classes:

1. Four or less residents excluding family and/or staff
2. Five to seven residents excluding family and/or staff
3. Eight or more residents excluding family and/or staff.

The homes are intended to provide a family-like setting where residents are encouraged to participate in normal activities as far as possible until they are able to return to normal life in the community. A time limit of six months duration governs the length of stay but this may be renewed.

Continuing clinical assessment is carried out to assist in rehabilitation and the social work staff are responsible for mobilizing the available resources. Funds are provided for comfort allowances and personal needs on a shared basis with the residents unless the resident has no personal income. Board, lodging, clothing, essential personal needs and educational or training expenses are provided at 100% cost by the Province. Details of amount and procedures are provided.

Supervision and Standards

The governing legislation does not provide specific standards in any detail. However, Branch policy is gradually filling this need by adopting the written standards of the Public Hospitals Act. Standards are also established by the accreditation procedure of the Canadian Council on Hospital Accreditation. Eleven psychiatric hospitals are now accredited under that body and three more will be accredited this year. Psychiatric hospitals have a great deal of autonomy within the guidelines of agreed objectives and budget constraints. Each hospital is managed by a trained hospital administrator. The professions involved in the services also have their own standards, ethics and by-laws and consultants are provided by the Ministry for additional support and supervision.

There are a variety of manuals and circular memoranda used for both administration and program purposes.

Interdependent Services and Admission Flow and Control

As a focal treatment resource for the mentally ill together with responsibilities for initiatives in the development of a variety of rehabilitative and preventive services in the community, psychiatric hospitals have linkages with almost the whole network of social and health services. Admission of in-patients emphasize severity of illness and "back up" existing hospital and other services within the region. Over fifty percent of the patients are informal referrals while the remainder are committed under the Mental Health Act by psychiatrists, physicians and judges. There is also partial hospitalization: day care, evening care, overnight and week-end care and a 72 hour "cool-out" period for unadmitted patients.

Non-Residential Alternatives

Psychiatric hospitals afford a broad range of non-residential options. These include out-patient clinics, after-care up to one year, activity and interest programs, therapeutic groups, sheltered workshops, behaviour modification, etc. Spin-off groups formed under community auspices also serve out-patients and ex-patients such as drop-in centres and group meetings with staff support provided by the hospital. These community programs would receive greater impetus if the psychiatric hospitals were transferred to community boards of management.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>7544</u>
Number of beds in Mental Retardation Units	<u>492</u>
Number in Approved Homes	<u>271</u>
Size of Facilities	
112-250 beds = 3 hospitals	251-500 beds = 6 hospitals
501-700 beds = 2 hospitals	701-974 beds = 4 hospitals
Total number of hospitals	<u>15</u>
Utilization based on patient days 1974	<u>74%</u>
Average per diem cost	unknown
Per diem cost of approved homes	<u>\$7.50</u>

Note: The great variety of part-residential and non-residential services that form an integral part of the total services would make it difficult and perhaps not too meaningful to cost out the pure residential element. For the same reasons and also because of the emphasis on short-term treatment and the significantly growing role of the active treatment hospital, utilization figures would not necessarily be an accurate efficiency indicator.

Funding

Operating Cost

The Province provides 100% of the operating cost through the Ministry of Health on the basis of detailed hospital budgets.

Capital Cost

No new construction is planned in the foreseeable future but there are ongoing renovations and alterations carried out by the Ministry of Government Services.

Cost Control

The administrators of each hospital submit a budget in conformity with the multi-year plan and this is discussed within the Ministry. A final amount is decided by Management Board. Regular performance reports are submitted to the Financial Controls Branch as with other hospitals. Although the psychiatric hospitals have considerable freedom and flexibility within the total annual funds allocated complement increases are not permissible. A total complement reduction of 200 staff was made in 1974-75 by withholding replacement of vacant positions and an additional 200 in 1975-76. There are some problems with overspending in individual facilities though expenditures are constrained within the overall program allocation in each budget year.

Federal Cost Sharing

The only way in which the Federal Government shares the cost of operation of psychiatric hospitals is through The Medical Care Act. Under this Act the Federal Government subsidizes the salaries paid to physicians employed by the hospitals for the amount of direct care given to patients but not for any administrative work they are required to do. The amount of subsidy is 50% of the national average cost; for Ontario this amounts to approximately 43% of the cost of direct care given by hospital physicians.

MAJOR ISSUES AND PROBLEMS

1. The continuing shift to treatment of the mentally ill in active treatment hospitals and the complementary role of the psychiatric hospitals create many problems in maintaining a balance between service gaps and duplications. There is a need for a more clearly defined division of responsibility.
2. There are a number of chronically mentally ill persons able to live in the community who are heavy users of very costly health, hospital and social services. These persons might be more effectively served at much lower cost in supervised group homes. (see report on Adult Group Homes)
3. Lack of flexibility in administration and staffing under Provincial auspices is frustrating for personnel and makes it difficult to attract good staff. Transfer of psychiatric hospitals to community boards of management might resolve some of these and other related problems.

PROGRAM Mental Retardation Schedule I Facilities

FUNCTION AND ADMINISTRATION

Legislation

Developmental Services Act 1974

Administration

Mental Retardation Facilities Division,
Community and Social Services.

Description of Service and Groups Served

The Schedule I facilities are institutional in character and generally remote from the main population centres. Most of them are comparable in size to Homes for the Aged except for the two at Orillia and Smith Falls which are considerably larger. Comprehensive inter-disciplinary services are provided for individuals in a wide age range including children and adults who are moderately, severely and profoundly retarded and multiply handicapped. Length of stay also ranges widely including short, intermediate, and long term care. Residential services combined with educational, developmental and training programs are designed to stabilize functioning at the optimum level in such areas as health, clothing and personal care, feeding, toileting, socializing. The programs range from basic to sophisticated levels with the ultimate objective of preparing the residents for return to community living. Approved homes in the community are used as a further step in this direction, beds permitting. Residents are discharged when appropriate to community based facilities, e.g. Homes for Special Care and Homes for Retarded Persons. Follow-up and support services are provided, although the size and scope of programs may be limited by the availability of these resources. Over the past few years, much has been done to update and improve services and the process is still going on.

Supervision and Standards

There are written standards developed by the American Association for the Mentally Deficient, but recently suggested levels of staffing are substantially beyond the resources available to the Schedule I facilities at this time. However, the long-term plan to establish many more community residences should gradually relieve the pressure consistent with the government's policy to maintain retarded persons within their own communities as far as possible. There are currently no standards prescribed by the legislation. Professional supervision is provided in all the many disciplines involved in providing the services.

Interdependent Services and Admission Flow and Control

Referrals are made to the facilities from many sources in the community and the social service and health systems, e.g. families, physicians, school boards, social agencies, courts and some from jails and psychiatric facilities. Assessment services are generally provided by the facilities according to a Rating Scale and persons are directed to the appropriate resource, whether a community agency or a facility for the retarded. Persons admitted to a Schedule I facility are provided with an individualized program and upon reaching an appropriate level of development are discharged to community based facilities when available. Each retarded person must be prepared for the change and the success of the transition depends to a considerable extent on good liaison with community resources. Facility staff are assigned to perform this function. The Mental Retardation Community Services Development unit of the Ministry oversees this phase as part of its responsibilities. The Schedule I facilities are presently crowded and beds are not always available. Persons discharged may go to Homes for Special Care, Homes for Retarded Persons, Nursing Homes, or sometimes, may live in the open community with staff support.

Non-Institutional Alternatives

Non-institutional alternatives are being developed under the aegis of the Mental Retardation Community Development Services unit, but some follow-up and support services are provided by the facilities themselves.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974
(including 3 units in psychiatric hospitals)

Rated bed capacity	<u>6,295</u>
Set-up beds	7,272
Approved home beds	<u>234</u>
Total beds	<u>7,506</u>

Size of Facilities

34-200 beds = 3 facilities 201-300 beds = 4 facilities

301-1715 beds = 5 facilities

Total number of facilities 12

(Mental Retardation units in psychiatric hospitals 142, 184, 200 beds)

Total number of units 3

Utilization based on number of days care,
calendar 1974 100% +

Average per diem cost, calendar 1974
(including mental retardation units
in psychiatric hospitals) \$33.50

(two higher cost specialized facilities are shown below)

CPRI London per diem cost (146 beds) \$102.00) monthly
) out-patient
 Surrey Place per diem cost (34 beds) \$189.00) **services**

[illegible]

Each facility submits a budget for review within the M.R. Facility Division. The consolidated budget is then adjusted to comply with established guidelines and constraints before submission to Management Board for approval with or without further alterations. Approved funds are allotted to the facilities as far as possible on the basis of the recommendation of the Budget Review Committee.

Capital Cost

Buildings are provided by the Ministry of Government Services, who continue to be responsible for renovation and other capital projects related to them. Long-term expectations are that no further expansion will take place except possibly in Toronto.

Cost Control

Facility costs are controlled in a number of ways:

1. Facility complement may not exceed levels approved by the Division. Staff costs comprise 80% of total operating costs. The Ministry must approve increases in the total complement of the Division.
2. M.R. Facilities Division staffing standards indicate levels of staff required for each facility.
3. Other Division guidelines provide for spending levels in other areas of cost such as clothing, certain travel, etc.
4. Government and Ministry manuals of administration govern the spending of funds.

5. Centralized purchasing of some items keeps cost of these items as inexpensive as possible.
6. The Division's annual budget review process is utilized to effect cost savings when possible.
7. Government budget constraints may further impose cost savings.
8. Monthly review of operating statements both at facility and Division level are utilized to control spending as necessary.

Personal Trust Accounts

Generally, only \$100. to \$150. is kept in a resident's personal trust account, although it is recommended that this amount be raised to \$500. in order to give residents more experience in budgeting and making personal purchases.

Public Trustee

The Public Trustee is billed for costs of care and maintenance in respect of residents with assets in excess of the \$1,500. permitted under the Family Benefits Act for whom he is acting. Approximately 200 to 300 residents have funds in excess of \$1,500.

Family Allowances, Comfort Allowances

Family Allowances are not generally collected by the facilities. Only residents of Approved Homes receive comfort allowances of up to \$15. per month. These may have to be reduced or discontinued if accumulated to amounts approaching \$1,500. in order to continue Family Benefits Allowances.

Federal Cost Sharing

The Federal Government under the Canada Assistance Plan shares the cost of assistance provided by these facilities to persons in need at the rate of 50% of shareable expenditures. The overall average recovery is about 34% of shareable expenditures. Accumulations of Public Trustee accounts on behalf of individual residents must be kept under \$1,500. if they are to qualify for sharing and this requirement is generally met in practise.

MAJOR ISSUES AND PROBLEMS

1. Overcrowding is presently a problem as may be seen by the number of beds in use over rated capacity. It appears that this will continue for some considerable time until the development of community

based residences and community and family support services are established to the point where reductions are possible.

2. Staffing standards are below recommended level and very far below standards set by the American Association for the Mentally Deficient. This is largely the result of financial constraints.
3. There is a shortage of community based residences to receive persons who are ready to leave Schedule I facilities. This may result in the regression of the residents concerned and contribute to problems of poor staff morale, high turnover rate, over population, etc.
4. Antiquated physical facilities with large wards and dining rooms and lack of privacy and space in many instances make it difficult to afford the personal dignity for residents consistent with the normalization concept.
5. There is a need for expansion of Approved Home beds, Boarding Homes, Half Way Houses, and similar programs for residents who need family living settings and to reduce the overcrowding. Some facilities are unable to use all the Approved Home beds available to them through lack of funds.
6. Inappropriate use of resources in some cases results from a lack of proper placement in the past of persons who are both retarded and mentally ill. A firm policy governing admissions to M.R. Facilities has resolved this issue.
7. In general, fewer inappropriate placements are now made in Schedule I facilities, but it is estimated that about 35% could go to community based residences directly. Others could also be kept at home longer with family and community support services. Provision of these services is part of the Government's plan, but is proceeding slowly.
8. There are some community based residences provided successfully by private business operations. Special funding considerations could expand this area rapidly.
9. Zoning and location factors are not a problem since facilities are separated from direct contact with the community.

PROGRAM Mental Retardation Schedule II and III Facilities**FUNCTION AND ADMINISTRATION****Legislation**

Developmental Services Act 1974

Administration

Mental Retardation Community Services Development Branch,
Agency Budget Review Office,
Community and Social Services.

Description of Services and Groups Served

These facilities were intended to serve severely and profoundly retarded children in the age group from infancy to 6 years but the program also includes older children, youth and adults. The facilities are owned and operated by non-profit corporations with boards intended to represent the local communities. In the past the services have placed little emphasis on personal development of the residents. Domiciliary care and health maintenance have been the main elements. A survey of needs and resources is currently underway to determine admission criteria, the specific needs of the residents in care and future planning in accordance with the overall program for the retarded. The management of the individual facilities is also under study to identify changes needed and determine staff support required. Much needs to be done in this program to raise both management and service levels.

There are two new Schedule II facilities being developed, one at Oakville and the other in Sault Ste. Marie. These particular facilities have been inherited by this Ministry inasmuch as they were planned while the program was in the Ministry of Health. The Oakville Centre will be somewhat different from the traditional Schedule II facility. It will most likely resemble a Schedule I facility in terms of broad programming and client population. The Sault Ste. Marie facility which is still on the drawing board is intended to provide a model that is quite different from the traditional institutional concept. Various services will not necessarily be under one roof and the concept of broad program will be emphasized using a variety of community agencies.

Schedule III facilities, originally conceived as comprehensive programs for the retarded on a regional basis under the administration of regional boards, have been established in one location. There are questions about certain aspects of this mode as it relates to the Provincially integrated program for the retarded and plans for further locations are not going ahead at this time.

Supervision and Standards

Specific program and accommodation standards are not set down in the Act and field supervisors are not provided. Periodic reports are, however, submitted by Ministry of Health staff concerning care and dietary practises and recommendations are made for improvement. The program manager considers it essential that staff support from the Province be provided to assist in the developmental aspects of the services. The Branch of administration responsible for this program is also responsible for non-residential and protective services for the retarded but the role of the district co-ordinators has not yet been detailed vis-a-vis the Schedule II facilities. The Homes for Retarded Persons may also be administered by this Branch as the Ministry reorganization evolves.

Interdependent Services and Admission Flow and Control

The Schedule II facilities are seen as part of the community based continuum of service involving services administered directly by the government and those purchased or operated by private community boards. Admissions to the Schedule II residences are controlled by the assessment units of the Schedule I facilities although some assessment services are also purchased in the community. Some of the children (about 25) are wards of children's aid societies and may eventually be placed in foster homes. Developmental day care, schools and work shop facilities are used where available and appropriate. Waiting lists for admission to the Schedule II residences are maintained by the Schedule I assessment units.

Non-Residential Alternatives

Protective services for adults living in the open community are provided by protective service workers in co-operation with local Associations for the Retarded, offering counselling, assistance with accommodation, employment and general advocacy. Children's aid societies have the responsibility of protecting retarded children. Family support and community services will also be developed through this Branch in local communities to enable children and adults to live in their own homes as long as possible. These would include developmental day care, parent relief, homemaker services, parent and child counselling, etc.

STATISTICS, FUNDING AND COST CONTROL

Total number of beds to December 31st, 1974	<u>776</u>
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Size of Facilities (including 2 general hospital units)	
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50-100 beds = 4 homes	101-126 beds = 4 homes
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Total number of homes and units	<u>8</u>
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Utilization based on days care in calendar 1974	<u>98%</u>
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Average per diem cost calendar 1974	<u>\$24.15</u>
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Funding	Operating Cost
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The Province pays 100% of the operating cost based on a forecast annual budget submitted for approval to the Minister who has the authority to vary the total amount requested. Payments are made monthly in advance and adjusted to the year end based on actual expenditures.

Capital Cost

The Province pays 2/3 of the approved cost of land, buildings, equipment, furnishings, landscaping, paving, etc., and cost of consultants essential to the preparation of the building project. All these provisions are detailed in the Regulation.

Cost Control

Each Schedule II facility must submit an annual forecast budget for the subsequent calendar year for approval by the Ministry. The current increase is based on the cost of living and salary increases, i.e. 12% for the year 1975. Budgets beyond this amount must be individually negotiated and overspending requires additional approval for the specific amount overspent. Family Benefits payments are not yet generally made; applications are being currently submitted. Provincial recoveries from Family Benefits revenues and other sources have not yet been determined and staff support for this purpose is being developed. Financial reporting is presently limited to an annual audited financial statement. In the future budgets will be based on individual program requirements as approved by the Ministry.

Federal Cost Sharing

At the present time the Federal Government shares 50% of the cost of care for adults only, based on the per diem cost in accordance with agreements under the Canada Assistance Plan.

MAJOR ISSUES AND PROBLEMS

1. These facilities are well established in their local communities and present no significant problems in community or neighbourhood acceptance. At present there are no plans to expand the program.
2. Standards of service in some facilities are considered to be too low. A census of residents is being taken to identify those who might benefit from developmental programs and eventually be placed in smaller community homes. The census will also be used for the improvement of standards. Increased costs will be a consideration.
3. It is strongly recommended that the private charitable corporation, presently the method of administration in the majority of these facilities, be maintained.
4. Research should be undertaken to determine the optimum size of such facilities (now thought to be about 100 beds) with reference to the need for a home environment and an appropriate analysis of costs.
5. The Branch administering this program is required to play an advocacy role for adult retarded in co-operation with local Associations for the Retarded. Because of its role in supervision and cost control there might be a conflict of interest in performing this function for the Schedule II facilities. Consideration should be given to a proper separation of the advocacy and funding/supervision functions.

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